PUBLIC HEALTH NURSING

JUNE
1946

PUBLIC HEALTH NURSING

VOL. 38, NO. 6 JUNE 1946

CONTENTS

Editor: MARY EDWARDS SHAW *Editorial Consultant:* ALBERTA B. WILSON, R.N.
Assistant to the Editor: JEAN R. STEPHENS

PUBLIC HEALTH NURSING

 Published monthly. Entered as second class matter April 1, 1932 at the Post Office at Utica, New York, under the Act of March 3, 1879. Acceptance for mailing at special rate of postage as provided for in Section 1103, Act of October 3, 1917 authorized August 27, 1918.

Subscription prices: United States and possessions, the Americas and Mexico, 1 year $3.00 (NOPHN members, 1 year $2.00). Foreign and Canadian add 50 cents. Single copies 35 cents. In combination with the *American Journal of Nursing*, $4.50 per year. In combination with the *Survey Graphic* and *Survey Midmonthly*, $5.50 per year.

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

1790 Broadway, New York 19, N. Y.

The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine PUBLIC HEALTH NURSING; and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members and its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

The organization has no jurisdiction over its membership. It serves in a purely advisory capacity and the acceptance of any of its recommendations is entirely voluntary.

Membership—Nurse, $3; General, $3; Sustaining, $10; Life, $100. Agency—employing nurses—full dues 1% of annual expenditures. Associate agency—clubs and societies not employing nurses, $5.
Placement Service—Nurse Placement Service, 8 S. Michigan Avenue, Chicago, Ill.

IN THIS CRITICAL *Evaluation of Foods* AND THEIR NUTRITIONAL CONTRIBUTION

ADVANCING knowledge has changed many of the older concepts of nutrition. In the critical modern-day consideration each food can be evaluated against the standard of nutritional requirements as suggested in the "Recommended Dietary Allowances" of the National Research Council for the promotion of nutritional health.

Many candies—the majority of the kinds and types eaten in the United States—make a good showing under this scrutiny. Such candies, in the manufacture of which milk, butter, eggs, fruits, nuts, and peanuts are used, make a contribution of the many essential nutrients contained in these ingredients.

In addition to their carbohydrate content such candies thus present biologically adequate protein, fats high in unsaturated fatty acids, important B vitamins and minerals, and in amounts which compare favorably with those contributed by many if not most of the commonly eaten desserts.

THE NUTRITIONAL PLATFORM OF CANDY

1. Candies in general supply high caloric value in small bulk.

2. Sugar supplied by candy requires little digestive effort to yield available energy.

3. Those candies, in the manufacture of which milk, butter, eggs, fruits, nuts, or peanuts are used, *to this extent* also—

(a) provide biologically adequate proteins and fats rich in the unsaturated fatty acids;
(b) present appreciable amounts of the important minerals calcium, phosphorus, and iron;
(c) contribute the niacin, and the small amounts of thiamine and riboflavin, contained in these ingredients.

4. Candies are of high satiety value; eaten after meals, they contribute to the sense of satisfaction and well-being a meal should bring; eaten in moderation between meals, they stave off hunger.

5. Candy is more than a mere source of nutriment—it is a morale builder, a contribution to the joy of living.

6. Candy is unique among all foods in that it shows relatively less tendency to undergo spoilage, chemical or bacterial.

This Platform is Acceptable for Advertising in the Publications of the American Medical Association.

COUNCIL ON CANDY OF THE **NATIONAL CONFECTIONERS' ASSOCIATION**

1 NORTH LA SALLE STREET
CHICAGO 2, ILLINOIS

When Liver Disease Calls for High Protein Intake

For protection of the liver cell against toxic injury, and for safeguarding optimal hepatic function, chief emphasis was placed in the past upon a high carbohydrate diet. This concept worked to the patient's detriment in chronic diseases of the liver, such as cirrhosis, when overemphasis on carbohydrate was combined with protein starvation.

Modern clinical experience has modified the older concept.[1, 2] The role of liver glycogen as a protective agent remains unchallenged, but it is now known that the bulk of liver glycogen is combined with protein for mutual stabilization, calling for an ample supply of biologically adequate protein.

Extensive observation in patients with cirrhosis has demonstrated the beneficial influence of a diet high in protein as well as in carbohydrate and B-complex vitamins. Only abundant protein can counteract the associated hypoproteinemia and the ensuing trend toward transudation which further aggravates the hypoproteinemia.

Meat is an excellent source of protein in the diet therapy of hepatic cirrhosis, not only because of the high percentage of protein contained, but especially because its protein is of highest biologic quality. In addition, meat is a good source of vitamins of the B complex.

---

[1] Ravdin, I. S.; Thorogood, E.; Riegel, C.; Peters, Rozanne, and Rhoads, J. E.: *The Prevention of Liver Damage and the Facilitation of Repair in the Liver by Diet,* J.A.M.A. 121:322 (Jan. 30) 1943.

[2] Stare, F. J., and Thorn, G. W.: *Protein Nutrition in Problems of Medical Interest,* J.A.M.A. 127:1120 (April 28) 1945.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Forearming Against Polio

EVERY COMMUNITY should have a plan to provide adequate care for infantile paralysis patients in all stages of treatment and this plan should be made *before* an epidemic occurs. Nurses can meet their responsibilities in assuring nursing coverage and quality of care more effectively if they work with other organizations who are concerned in the complete program.

Reported cases of infantile paralysis have shown a marked increase over the past five years. In 1941, there were 9,086 cases; 4,033 in 1942; 12,429 in 1943; 19,029 in 1944; and 13,514 in 1945. Now in early summer there is no ground for believing that there will be any great change for the better in 1946.

In view of the continued nursing shortage, it is essential that the services of professional nurses be used with as much economy as is consistent with safe care. Many localities have made effective use of practical nurses, nurse's aides, and volunteers under the supervision of graduate nurses. Due to the efforts of the National Association of Practical Nurse Education, the Polio-Emergency Volunteers program of the National Foundation for Infantile Paralysis, and the American Red Cross supplementary courses for nurse's aides, a larger number of auxiliary workers with some instruction and practice in nursing care of patients with infantile paralysis are now available. Auxiliary workers should be used only in situations where graduate nurses experienced in the care of patients with infantile paralysis can give supervision. Professional nurses have an obligation to get ready for such responsibilities if safe care is to be provided.

The number of graduate nurses with special preparation who are needed in the community, the type of preparation required, how and where it should be given, and ways in which prepared nurses can be used most effectively should be carefully considered.

Planned staff education and assistance on the job have proved effective methods of giving instruction to a considerable number of nurses in a community. Since nursing in infantile paralysis is based on medical recommendations which vary according to the conditions of individual patients, nurses should be prepared to carry out whatever procedures are ordered by the attending physician. Advice from local physicians who are responsible for medical supervision of infantile paralysis patients should be sought when plans are made for instruction of nurses. Instruction and practice should include all aspects of nursing care and not be limited to a specific procedure such as the application of hot packs.

Various resources are available for local nursing groups in planning instruction which will help them meet their responsibilities to the infantile paralysis patient. The consultant in orthopedic nursing in the state agency for crippled children and the orthopedic supervisor in a local hospital or visiting nurse association are especially well qualified to plan and give nursing instruction. A physician may be called upon to discuss medical aspects and the physical therapist to demonstrate how bed positions and activities are related to the treatment she gives. The National Foundation for Infantile Paralysis or the local chapter has a generous supply of pamphlet material. The Joint Orthopedic Nursing Advisory Service of the NOPHN and the NLNE which is financed by a grant from the National Foundation offers the following: field advisory service; bibliography and reprints on nursing care of infantile paralysis available in quantity; slides (2 x 2 kodachrome) for loan; and scholarships for the preparation of supervisors in orthopedic nursing in hospitals and public health agencies.

Elsewhere in this issue (page 315) is an announcement from the NFIP requesting nurses

who are willing to assist in the care of infantile paralysis patients during the 1946 epidemic period in their own communities or elsewhere to register with the Foundation. Nurses who can be released are urged to volunteer for such assistance. An opportunity for service is combined with the privilege of obtaining experience in the newer methods of medical and nursing care of infantile paralysis.

Cost of Service

IN 1932 the NOPHN published a handbook, *Principles and Practices in Public Health Nursing,* especially prepared to assist executives and board members in computing the cost of a home visit. The material for this book had been gathered by a committee of which Dr. Haven Emerson was chairman. Prior to 1932, few studies of cost had been made by visiting nurse organizations although more or less uniform methods had been attempted. While the methods which had been evolved were satisfactory in some instances, it had been found almost impossible to formulate a plan which could be fitted to most of the agencies.

Since 1932 voluntary agencies have been well schooled in the cost of home nursing visits through preparing annual cost statements for the insurance companies. Community fund budget committees have frequently been impressed with the fact that nursing agencies appear to know just how much their services cost.

During the past few years there has been an increasing realization that both voluntary and official health agencies need a basis for determining cost of service on a unit of time as well as a visit basis, and nurse directors have asked for assistance in determining the cost of services other than home visiting. Agencies have been asked to sell services to industry, to other agencies, and to schools of nursing for educational activities. At the Biennial Convention in Buffalo in 1944, the subject of computing costs per hour was discussed at some length. Methods for estimating such costs were presented by Emilie G. Sargent of the Detroit VNA and Katherine E. Peirce of the John Hancock Mutual Life Insurance Company.

Following the Biennial, the Cost Analyses Committee of the NOPHN appointed a subcommittee with Mabel Reid of the VNS of New York as chairman to consider further the problem of determining public health nursing costs per hour. For more than a year this subcommittee, which includes representatives of the United States Public Health Service, insurance companies, community chests, and private and combination agencies has been drawing up objectives and making plans for time and cost studies which are the necessary basis of any attempt to work out a formula which will enable agencies to produce cost per hour figures for each type of service provided by them.

That there is a wide divergence at the present time in the charges for service other than home visiting is evident in the figures on selling service other than bedside nursing taken from the 1945 Yearly Review of the NOPHN. (See page 300). The lowest charge according to these tables was 80 cents for nursery school work and the highest, $6.67 an hour for teaching in schools of nursing.

Administrators of public health nursing are very much aware of the increasing use of nurse time for services other than bedside nursing, and need methods of determining costs for such activities as interviewing in clinics and health centers, industrial health work, and work in nursery schools. NOPHN has submitted the objectives and plans of the Cost Analyses Committee to a number of sources, asking for financial and personnel assistance. As soon as possible the beginning of these studies will be announced.

NELLIE R. DILLON, CHAIRMAN
COST ANALYSES COMMITTEE

Understanding the Patient

By NATHANIEL CANTOR

THE EDITOR has asked me to discuss the role of interviewing by the public health nurse. In order to focus the discussion I should like to comment briefly on (1) the function of the public health nurse and (2) her preparation for carrying out her function.

In describing her function we can do no better than to quote what is approved by the Committee on Nursing Administration of the National Organization for Public Health Nursing:

> The functions of public health nurses are to help make known scientific facts about health; to help create positive attitudes toward the acquisition and maintenance of health; to encourage and teach the use of health and medical resources; to contribute toward the adjustment of social conditions to the end that the family will become resourceful in meeting their health needs. The public health nurse has a community responsibility in keeping before the attention of its citizens the needs and reasons for adequate funds, facilities, and services; in helping the community to understand and apply efficient economical methods of administering and coordinating nursing services in order to obtain maximum benefits without duplications and inequalities.*

Many types of service are covered in the above statement. The public health nursing program includes many activities—maternity care, child health supervision of the infant and school child, adult health supervision, industrial nursing, communicable and noncommunicable disease control, orthopedic service, and assistance in the fields of sanitation and vital statistics.

Obviously no single nurse would be qualified to perform efficiently in any of these areas without specialized training. Differentiation in approach and content is required. Each of these fields represents a specific kind of public health nursing. The common core is found in the type of preparation a public health nurse receives. This leads us to a brief comment on her preparation.

Nathaniel Cantor is chairman, Department of Sociology and Anthropology, University of Buffalo, New York; also author of Crime and Society, Employee Counseling, and The Dynamics of Learning (in press).

PREPARATION FOR PUBLIC HEALTH NURSING

The preparation of nurses and physicians is primarily concerned with the accumulation of medical data and techniques. The medical student becomes a high grade technician and the nurse an apprentice technician. Neither in the medical schools nor in schools for nursing is there a marked tendency to offer the student the time and opportunity to ask and reflect upon what all these facts of disease and technique *mean* in the patient's life.

Schools of medicine and nursing, it seems, are set up for medical students and candidates for nursing. They should be set up and administered not for the prevention and cure of disease, but for the prevention of disease and the protection of the health of *individuals*. The remark is often made that people, and not diseases, are to be treated. Another way of stating this is: What does illness mean to the total personality? The development of psychosomatic medicine in the past decade reflects an increasing awareness of the psychological factors in the etiology of many diseases. The reports of admissions in some of the leading hospitals show the tremendous significance of psychological disturbances as factors in the onset of disease.

If we really believe that greater emphasis should be placed upon what illness and public health mean to the total personality, then we should introduce in medical and nursing training something beyond the sheer accumulation of facts and techniques. The question arises, however, whether this attitude toward the patient and members of a community can

*"Public Health Nursing Program and Functions." PUBLIC HEALTH NURSING, June 1944, p. 280.

be taught. Perhaps this feeling for another has to be present before it can be developed. This means that the problem becomes one of carefully selecting candidates for nurse's training. An alternative, perhaps, is to separate nurse candidates into two large groups. In the latter case we would have something comparable to the nurse's aides which proved so helpful during the war. That is, there would be a large group of nurse's aides and orderlies who would fuss with the larger part of the mechanical and routine detail which makes the life of the nurse so miserable today. This would relieve the nurses of routine duties and leave them the time to attend to the patient as a person.

This leads us at once to some perplexing difficulties. The nurse may not inquire too far into the meaning of illness, personal hygiene, and community health standards until the physician also appreciates the fact that a *person* is ill, and that the attitudes of the members of a community are of vital importance. A physician interested primarily in the disease will issue different kinds of orders to the nurse than the one who is interested primarily in the patient or the people. The nurse who appreciates the meaning of illness to child, adult, workers or mothers may not criticize the physician or refuse to carry out his orders, or suggest other procedures. A physician who is merely a skilled technician (or a public health officer or medical group perfunctorily issuing standing orders), assisted by an understanding public health nurse, is not a happy combination either for the nurse or for the patient or for any recipient of the public health service.

I am grateful that I can avoid the responsibility of commenting upon what changes in the curriculum of medical schools and schools of nursing should be made and upon the problems of how to select promising candidates for the training. I shall assume that the public health nurse is the kind of person who is constantly aware of the individual involved in any service she performs.

The nurse is in intimate professional contact with the patient. She sees the patient in a natural setting much more so than the physician. Indeed, the nurse is of far more importance than the physician in the home, school, clinic, and shop. She is able to see the meaning of illness or its prevention in relation to the total adjustment of the personality. She has the opportunity to establish rapport with the patient. Her function in interviewing the patient is to help him relieve his fears and anxieties concerning the problem or his illness; to help him discover for himself the meaning which lies behind his complaint or her request; to detect signs of tension in the individual; to help him express these tensions; to make as clear as possible, in light of the patient's ability to understand, just what is being done to and for the patient. In brief, the public health nurse possesses not only the competent techniques of her profession but even more importantly knows how to use them in helping a person come to grips with the illness or problem which bothers him or may be of concern to him. This last point calls for some elaboration.

KNOWLEDGE AND TREATMENT

In functioning as a public health nurse knowledge of certain techniques and a limited amount of medical data is essential. This can be taught. What is more difficult to learn is how to apply that knowledge in the nurse-patient relationship.

From the point of view of the nurse who wishes to understand the medical difficulties or what technique to employ, the patient is merely one more "case." The patient from this point of view is merely the carrier of the illness or problem which the nurse seeks to understand. What is left out of the scientific account of what is happening is the understanding of the illness or problem, the meaning of the whole experience to the patient. A patient is not a guinea pig who possesses a "beautiful cancer," or has a vitamin deficiency. The patient is a person who wants to be helped in or helped to understand his situation. The appreciation of this point of view will help the nurse to apply her technical information to the individual patient. *The nurse requires insight into people as well as knowledge of certain skills.*

Getting well or remaining healthy is not merely a matter of prescriptions or proscriptions. It is a matter of what the patient as a person considers important. This is supported by the remark so often heard on the part of physicians, "The patient simply has no will to live." This is also borne out by the experience of every nurse and physician; namely,

many patients shop around among physicians until they find someone who will tell them what they want to hear.

The job of the public health nurse in any area which involves interviewing patients or individuals is not merely to add to scientific knowledge or to collect data or to clear up a medical problem or even to carry out a physician's order. *Her primary job is to help a human being,* over and above getting rid of or preventing a physical ailment. The professional interview between nurse and patient offers a grand opportunity to help a person come to grips with himself.

COMMON ELEMENTS IN THE INTERVIEWING PROCESS

Somehow or other every nurse who is going to do any interviewing with patients should be deeply aware of the following elements. The awareness should be so deep that it becomes part of the nurse's professional self. (1) The nurse interviewer will understand the dynamics of human behavior in its individual and social aspects. (2) The nurse will be concerned primarily with understanding and not judging the patient. (3) The nurse will keep at the center of the interview the importance of the patient's problems and feelings, not her own. (4) The nurse will clearly recognize that beyond the sheer medical aspects of the problem the individual patient must help himself, in his own way, and at his own speed.

These elements are present in every interview. The way in which they will be applied, however, will vary in the light of the particular kind of problem presented. The nurse can control the discussion of the interview by permitting the patient to discover for himself during the interview what he really wants and what he really wants to do, qualified, of course, by the medical needs of the problem.

A patient who gets the feeling that he dares to be himself in the presence of the nurse who assists him has no need to be on the defensive. To give a patient this feeling the nurse must possess great skill in applying the kind of understanding characterized by the elements common to all professional interviews.

PERSONALITY OF THE NURSE

Most of us live through childhood, adolescent, and adult experiences without realizing how little guidance we receive or give. In our relationship with our parents, sisters, brothers, friends, teachers, and later, with husband or wife and children, we exploit or are exploited by each other. We use each other in order to dominate or to befriend. Rarely are we ready to stand by and permit ourselves to be used by the other person in precisely the way that person wants to be helped. We are taken advantage of in order to satisfy the other person's emotional needs. In turn, we use others to satisfy our tensions and anxieties. We are afraid of the new, hidden, and powerful forces of creation which threaten our own established habits and the conventions of society. The positive creative forces of individuals which express their differences from those about them must be channelized into the encrusted bed of tradition. We fluctuate between attitudes of praise and blame in our intimate contacts with each other where emotional ties are strongest. We have to preserve whatever we have at stake and maintain our self-regard or the respect of others. Hence, we shuttle between dominating, excusing, or yielding to others. We wish to control or want to be loved. Rarely in these deep contacts does one stand aside and accept others just as they are. We are driven to create in our own image. It strikes one, if and when it does, as shocking and amazing how rarely a child or adult is permitted an effective margin of genuine self-determination. It is difficult, wholeheartedly and unaffectedly, to accept those who differ from us.

Nurses share these inevitable needs to dominate or to be well thought of, to be approved of. There are not many individuals willing to assume the responsibility of self-discipline so that they may become relatively immune to the judgments of others and are willing to let others think, feel, and act in ways relatively different from their own. Such inner steel strength is acquired through painful self-discipline and professional training.

The nurse who brings to the interview a set of disciplined attitudes based upon insight into human relations knows and feels her own responses and has learned to control them. She is interested in understanding and accepting the difficulties expressed by the patient. By recognizing the right of each patient to be different from each other patient and by communicating that feeling to them she frees them to express themselves.

The understanding nurse will not exploit the patient for the release of her own tensions. The interview will not be used by her to solve her own emotional difficulties. She will refrain from imposing her personal points of view upon the patient. She will not ridicule or "talk down" or "baby" the patient. Aware of her own ceaseless struggle to dominate or submit, she will appreciate similar conflicts in others and permit them a large degree of self-determination.

This kind of skilled understanding of another human being is not easy to acquire. Since each of us feels that we are expert in living our own lives, as we are, we share the tendency to believe that we are expert in leading other people's lives, as we are not. Without an unaffected, warm, and genuine interest in other people no nurse can communicate to a patient the feeling of confidence so essential in that relationship. Emotion always responds to emotion. We rarely misinterpret fundamental feeling tones. A client who senses genuine warmth even though it is not communicated in words will respond to it. But that warmth cannot be conveyed unless it is a part of the very being of the nurse. To help a patient understand, in his own way, the significance of his illness or medical need to himself and for others is the function of the skilled interviewer in public health nursing.*

*This point of view is fully developed in a forthcoming volume: Nathaniel Cantor, *The Dynamics of Learning*, to be published September 1, 1946, by Foster and Stewart, Airport Publishers, Buffalo, New York.

NATIONAL SOCIAL WELFARE ASSEMBLY

PROVISION of a means of consultation and conference on social welfare needs and problems, and provision of leadership and facilities for social welfare agencies, groups of agencies, and individuals to plan and act together in matters of common interest are the purposes of the National Social Welfare Assembly, officially launched on April 29. With Charles P. Taft of Cincinnati as president and Robert E. Bondy, formerly of the American Red Cross, as executive director, the new organization succeeds the 25-year-old forum group, the National Social Work Council. Its membership is greatly broadened as compared with the parent body, comprising two representatives, one lay and one staff member, from each of 40 affiliated organizations, and 40 members-at-large. In the latter category, by drawing upon people in government positions not eligible otherwise and people from local communities, it is hoped the governmental and voluntary bodies can be brought closer together.

The Assembly includes also "associate groups" which are autonomous groups of national agencies, represented in the Assembly, and eligible to receive service.

The National Health Council is an associate group and, by agreement between the two organizations, is recognized as the health division of the Assembly with separate corporate entity and complete authority to act without relation to the Assembly.

Membership in the Assembly resides in the individuals elected rather than in the agency that elects them and the Assembly has no authority over its affiliate organizations. Affiliated organizations, not being direct voting members, will not be bound by any vote of the Assembly except by specific concurrence. At the same time the Assembly, being made up of members voting as individuals, will be free to take needed action in its own name. The expenses of the Assembly will be met chiefly by contributions from affiliates, foundation and individual grants.

Strengthening community services for veterans is one of the early problems to be considered by the Assembly and establishing a liasion between government and voluntary social welfare organizations another of its immediate aims. Services to affiliate organizations will include assistance in program planning and administration, and informational and common interest services.

The National Organization for Public Health Nursing continues as a cooperating organization in the National Health Council and has voted also to retain the membership in the National Social Welfare Assembly formerly held in the National Social Work Council. Ruth Houlton is a member of the Board of the Council and the Executive Committee of the Assembly.

Camp Values for All Children

By JUANITA M. LUCK

CAMPING IS important because of the unique contribution it makes to individuals through participation in group experience. Group living is experienced in an outdoor community and a leader shares with the campers the development of a program which is personally satisfying and socially desirable. The affairs of community life such as work, shelter, health, safety, fun, and adventure are basic to these programs. Farming, music, dramatics, arts and crafts, woodcraft, sports, games, and social recreation are the usual activities for campers.

The success of the camp group depends upon joint participation and responsibility of counselors and campers. Each camper comes into his summer community with interests, skills, desires, and needs which he has formed in his individual family, neighborhood, and community life. Individual differences must be understood and the right of self-expression accepted.

In order to meet the needs of children, camping programs must include a variety of interests. The individual camper chooses to participate in these activities. His relationship to other campers and the camp is voluntary. He looks forward to camp life and plans his part. Adults and children should share in the preparation, the camping, and home going.

The handicapped children will find the same values that other children do in camp. Camp is primarily a recreational experience with social, health, and educational values. The camper may want to try out his ideas, learn new skills, be with his friends, or make new ones. Factors other than the ability to participate in physical activities are important in considering camp for any child. The daily pressure of living and playing in groups, learning new skills, and sharing responsibilities are all part of individual adjustment to camp experience. With the help of understanding camp counselors, the handicapped child and the child without physical handicaps may enjoy and benefit from the same camp.

Miss Luck is consultant in group work and recreation, Children's Bureau, U. S. Department of Labor.

THE MEANING OF A HANDICAP

The meaning of a handicap is different for each child. In providing services for children with physical handicaps, it is necessary to consider all aspects of the development of the child—physical, emotional, mental, and social. Planning for children with handicaps should focus on their total needs rather than on the differences which may be inherent in their handicaps. However, realistic recognition must be given to the limitations of the physical handicap by all persons working with the child, with specific knowledge of what this limitation means to and for the child. It is important to realize that the extent of a handicapping condition is often greater than meets the eye. A child may appear physically fit but may have a cardiac involvement or diabetes. Children with similar handicaps cannot be considered alike in all aspects of their development. Differences stemming from experience in family groups, in friendship groups, and mother relationships may affect the attitudes, interests, adjustment, and adaptability of the child. This is why we must always consider the individual camper a person with special limitations and potentialities for growth and social development.

WHO SHALL GO TO CAMP?

Physically handicapped children who are able to participate in regular camping programs with nonhandicapped children should be helped to do so. This requires careful planning on the part of both medical and camping personnel. It can be, however, a

worthwhile experience for all children in the camp. The handicapped child whose physical condition allows him to participate in enough of the camp program to become a part of it should be considered for camp. The decision as to whether a child can participate in a regular camping program cannot be made without knowledge of the medical situation, including diagnosis, past history, present treatment, and recommendation, and the implication of these for the child in camp. A child with a condition requiring intensive medical treatment or bed rest should not be sent to a regular camp. Such medical care would not be available in the camping program. A child who cannot move about or is almost completely dependent on other persons for his personal needs in dressing and eating could not participate in group life in the usual camping program.

COMMUNITY CAMPS FOR CHILDREN

Most communities offer camping services under the auspices of such agencies as social settlements, public recreation departments, youth-serving organizations, Salvation Army, churches, and similar organizations, or by private directors who own and operate camps without agency sponsorship. Information on camps can be secured from councils of social agencies, local sections of the American Camping Association, departments of public recreation, and private camp directors. Persons working with handicapped children should not overlook the importance of selecting an appropriate camp. Who are the children who will go to this camp? Is the camp program one which would benefit a handicapped child? Does this camp provide adequate health, medical, and nutritional services? What about the staff? What training do they have for their jobs? Would the staff accept medical supervision and consultation in working with the handicapped child?

Good standards in personnel, facilities, and program are essential to any camp. In addition to these, particular attention must be given to certain protective measures for the child with a physical disability. What these are will depend upon the needs of the children being served.

The camp director and staff are responsible for each child in the camp group. The child without physical handicaps must be considered in relation to his own and other campers' experience, and the way in which the children without physical handicaps behave in association with the handicapped child will greatly affect the camp life for both. The camp staff must be prepared to make associations easy between children in their camp life—for the maximum benefit of all. This is the task for which specific counselor training and professional consultation are needed during the camp period.

AFTER CAMP IS OVER

Spontaneous fun in camp may be the beginning of community recreational interests among children which they take home into their own community life. Participation in community recreational programs should be the next step. Campers should be informed about year-round recreational programs under public and private auspices.

Group and individual camp records would be valuable to the other adults who work with the handicapped child in the community. Of course, the medical and social records should always be referred to the appropriate agencies.

The preparation of a child for camp, responsibility for him during camp, and follow-up when camp is over, are parts of a process in which camping and medical personnel share. After a suitable camp experience campers should return to family and community life happier, healthier, and more self-confident.

A COMMUNITY PLAN

Any community group seeking to serve children must work in cooperation with other groups. In most communities camp authorities can obtain advice from public and private agencies whose primary interest is service to the handicapped child. Every state has a program providing diagnosis, medical and surgical care, hospitalization, and after-care services for the crippled child. Consultation from such agencies on medical, nursing, medical social work, and nutritional programs should be available to camps wishing to serve handicapped children. Joint planning by camping and medical authorities for services to handicapped children is an important step in planning community camping for all children.

Guide for the Camp Placement of Handicapped Children

Report of the Committee on Camping for the Handicapped, The Children's Welfare Federation of New York City

SOCIAL, recreational, and health agencies no longer look upon camping as an isolated experience in a child's life. It is now accepted as an important tool in the year round work with a child. If these agencies and their clientele—the children they serve—are to gain the greatest benefit from camp, a careful job of selecting a particular camp for a particular child is a requisite. This is of paramount importance in camping for handicapped children.

Recognizing the lack of sufficient information relating to camping facilities for handicapped children, a group of representatives of agencies in New York City working with handicapped children met in February 1945 under the auspices of Children's Welfare Federation to consider a survey of the situation. As a result, a Committee on Camping for the Handicapped, sponsored by the Federation, with Mrs. Alice FitzGerald, executive director of the Association for the Aid of Crippled Children, as chairman, was formed to study the problems of handicapped children in relation to camping. The chief objective of the Committee was to interest camps for physically normal children which have already accepted some children with handicaps to take more of them and to encourage those who have not heretofore taken any, to accept such campers. If even one child is accepted, it will be helpful and will prove to the camp that such children can be included safely. To accomplish this, the survey was made which resulted in the preparation of a "Guide for Camp Placement of Handicapped Children" (reprinted in full below).

The purpose of the guide is to make available to those who are interested in camping for children pertinent information concerning handicapped children who have usually been and still are largely excluded from camps for physically normal children. The Committee which prepared the guide believes it will serve as a means of increasing the opportunities for physically handicapped children to enjoy a normal camping experience.

However, this will be possible only if such children are carefully selected with due consideration for the type and degree of handicap, the physical setup of the camp, and the character of its personnel and program. Therefore, the Committee has assembled, from material obtained from experts in the various fields, information concerning the most common problems to be considered by camp administrators and sending agencies in determining the possibility or advisability of including handicapped children among their campers.

Nurses on the staffs of sending agencies or at camp will find helpful statements in the guide which will lend authority to any decision they may need to make. The committee hopes that the guide will be used by the individual nurse, the camp physician, and the camp director for the particular group in which they are interested.

General Considerations

1. Selection of Campers

Only those children should be accepted whose handicaps have been under regular and expert supervision and whose complete records are available to the camp.

Children should be accepted only after consultation with the physician, clinic, or agency giving such supervision. A wise decision as to the advisability of sending any child to camp can only be reached if the

physician or clinic understands the conditions the child will meet at camp; and the camp administration understands the nature of the child's handicap and any limitations it may impose on his activities while at camp.

2. Camp Program

The handicapped child should be encouraged to take part in the camp program as fully as his handicap will allow. He should be made to feel that the program is a challenge to him to take part on an equal footing with his fellow-campers wherever possible. However, the camp program should be sufficiently flexible so that not every child is expected to participate in every activity at the same time. This will allow the handicapped child to remain out of activities unsuited to him without incurring the stigma of "difference."

3. Supervision

When a camp has accepted a number of handicapped children, they should not be segregated into a special group. Such segregation defeats the purpose for which they were sent to camp.

Again, children with handicaps should be grouped with children of their own age and not put in groups with younger children. This has sometimes been done to give them the advantage of the closer supervision which younger children receive. This advantage is more than offset by the injury to their self-esteem resulting from being grouped with younger children and from being singled out for special and "different" treatment.

It is particularly important for the supervisory staff of a camp accepting handicapped children to interpret intelligently to the counselor staff the meaning and significance of records and inter-agency reports, both social and medical. The relationship between counselor and supervisory administration personnel must be such as to guarantee maximum cooperation in a joint effort to know the child and thus promote healthful adjustment to the camp experience and meet any emergencies that may arise.

The personnel of camps accepting handicapped children should include a registered, professional nurse. Camps taking children with certain types of handicaps should have a resident physician. With other types of handicaps, a physician should be on call to meet emergencies.

4. Physical Set-up and Administration

It is particularly necessary for camps accepting handicapped children to meet established standards for housing; sanitation; safety; character and number of counselors and special staff; adequate diet, and so forth. Sending agencies have a responsibility here for carefully evaluating camps in respect to these accepted standards before applying for places for the handicapped.

5. Camp Records

A record, as complete as possible, of the child's medical and social history should be on file at camp.

In every case a report should be sent to the sending agency when the child returns home. In making this report, the camp should keep in mind that the camping experience is an integral part of a total year round rehabilitation program; and that those responsible for the total program want and need all the information they can get. Therefore, the report should include such significant points as the camper's adjustment to the camp program; his relationship with other campers; any evidence of an attitude of invalidism or of persistent voluntary segregation. The sending agency will also be interested in any display of special talents or capacity for leadership and a note by the nurse or physician as to the child's health while at camp, especially as related to his handicap will be very valuable.

Special Considerations

In addition to the general considerations noted above there will be certain special points to be considered in the individual handicaps. Such special considerations as drawn up by authorities in the various fields are as follows:

CARDIAC

The advisability of cardiac children attending regular camps is still a moot question.

It is absolutely essential that the correct diagnosis including the functional and therapeutic classifications be secured before a child is accepted for admission. A classification of patients with diseases of the heart has

been prepared by the New York Heart Association and is available for distribution. Since camping for cardiac children is still in the experimental stage, deviation from these classifications may jeopardize the health of these children as well as the future admission of other cardiac children to camps.

It is recommended that only those cardiac children, classified as IA Potential and Possible Heart Disease, who have had no new or recurrent acute rheumatic infection within two years and who are recommended by an affiliated cardiac clinic of the New York Heart Association (this report was written for New York groups but is, of course, applicable to situations everywhere), may be approved for admission to summer camps.

Cardiac children may be classified as:

IA: Patients with cardiac disease and no limitation of physical activity. Ordinary physical activity does not cause discomfort. These are patients with cardiac disease whose physical activity need not be restricted.

Potential Heart Disease: Patients in whom no cardiac disease is discovered but whose course should be followed by periodic examinations because of the presence of history of an etiological factor which might cause heart disease.

Possible Heart Disease: Patients with symptoms or signs referable to the heart but in whom a diagnosis of cardiac disease is uncertain. Cardiac children so classified should not be segregated but should be integrated into the normal camp program.

Physical Setup. Level terrain is best. Houses and cabins are preferable to tents. Overcrowding should be avoided. The regular well balanced camp diet is adequate.

Medical Supervision. The staff should include a resident physician as a regular member of the camp personnel. A fourth year resident medical student would be acceptable if a graduate physician is not available.

Supervision. Mature counsellors should be assigned to the units in which there are cardiac children. The number of children per counsellor should not exceed 6 to 8 and is contingent upon the maturity and experience of the counsellor.

Camp personnel should understand the necessity for reporting immediately to the physician minor respiratory infections in cardiac children.

It is advisable that all children, particularly cardiac children, should not be permitted to sit around in wet or damp bathing suits.

Camp Program. The camp program should be well balanced in terms of active and quiet activities. Competitive athletic activities should be avoided but cardiac children should be permitted to participate in a non-competitive capacity, such as scorekeeper or timekeeper. These children should be encouraged to participate and helped to obtain satisfaction from non-competitive activities, such as arts, crafts, nature lore, stage craft, dramatics, story telling and the like.

It is important that these children use the rest hour for resting.

DIABETIC

A camp for non-handicapped children might reasonably be expected to take a diabetic child if:

1. The medical supervision is adequate—resident physician or registered nurse—for the care required.

2. The child's own physician would give assurance that the child's diabetes was well controlled and that the child had sufficient training and intelligence to resist the temptation to break his diet, to recognize the symptoms of insulin reactions, et cetera.

The older the child is, the more feasible it becomes to have him at a camp with non-diabetic children because he would have had time to have learned about himself in relation to his disease, and could be expected to cooperate without the strict control that is maintained at a camp operated exclusively for diabetic children.

One of the main objectives for the operation of Nyda, the New York Diabetes Association's Camp, is the education of the juvenile diabetic under favorable conditions. This training will be of value to him for the rest of his life, as the more the diabetic knows about his condition, the more intelligently he can cooperate with his physician. This results in a more normal life with fewer medical complications due to his diabetes.

Physical Setup. Rugged type of camp facilities are not practical for this group because of the special care they must have. Dormitories must be close together as 24-hour nursing supervision is required; toilet facilities ample because of urine analyses done twice a day; and kitchen large and well equipped as a special tray must be prepared for each child. Any terrain suitable for a camp for normal children is all right for diabetics.

Supervision. Children must be under constant observation and medical supervision because of the possibility of insulin reaction. Since camp life is usually more active than the life normally led by the child, adjustments in the amount of insulin and nourishment may need to be made. A resident physician must be at camp at all times. Physical check-up a few days after arrival is essential.

Camp Program. Strenuous and quiet activities should be alternated. Children may participate in all games that they would in a normal camp. Because many of the children have been overprotected at home, they do not respond to group play as readily as normal children. They are used to doing things on an individual basis, and quiet activities such as arts and crafts are popular. With proper handling, however, they adjust to group play and should be encouraged to do so.

Overnight hikes are not practical, because of meals and possible night reactions. However, outdoor cooking is permitted with proper dietary consideration.

Child should be taught self-administration of insulin, diet substitutions, methods of testing urine for sugar, et cetera; and that his handicap will not interfere with a normal life if he takes proper care of himself.

EPILEPTIC

An epileptic child who is mentally normal and whose seizures are controlled on medication, is eligible for a camp where there are non-epileptic children. Children who have frequent seizures (one or more per week) or other diseases of the nervous system, require special attention and should go to a special camp.

Physical Setup. Mountainous or precipitous terrain is permissible as long as other campers are present. There is no need for special diets or unusual housing facilities.

Supervision. Staff members should understand epilepsy and remain calm, should a seizure occur. The medical staff should understand that regularity in medication is essential in the treatment of epilepsy; and in the case of small children, supervision is indicated. This requires no additional staff as medication is usually taken at meal time or at breakfast and bedtime.

There is no treatment to be administered during an attack. An effort should be made to prevent the child from injury. Lower child to floor away from furniture or other hard objects. Occasionally, it is helpful to place a handkerchief or a rolled newspaper between the back teeth on one side of his mouth. Remain calm. When the child regains consciousness, he may or may not wish to lie down, because he is drowsy or has a headache.

Camp Program. So long as seizures are infrequent, the incidence of accidents is so small, they might be ignored. Moderated precautions are required for those whose seizures recur at a rate of more than one per month. Particularly, this is true in swimming, boating, ladder climbing, and outdoor cooking. There are no other limitations in the general camp program.

HARD-OF-HEARING AND DEAF

Hard-of-hearing children and those with severe hearing defects should be placed in a camp with normally hearing children and not segregated.

All counsellors should understand and keep in mind the effect of distance on hearing.

Hard-of-hearing or deaf children should be housed with good hearing children so that they can be informed of any emergency which arises especially at night.

Camp Program. Since this guide covers all children with hearing defects from a slight impairment to complete deafness, the camp program is discussed from the standpoint of (1) children with hearing defects, including deaf and (2) children who are deaf.

1. For all children with hearing defects, including deaf
   a. In all group activities, such as athletics, dramatics, dancing, singing, et cetera, the child should be allowed to place himself for best use of his hearing and for lip reading. Counselors must be aware that the greater the distance from the source of sound, the greater difficulty the child has in hearing.
   b. Whenever possible, the child should be given the opportunity to improve his speech and lip reading.
   c. Swimming (especially diving) should not be allowed unless the physician approves, especially when a child has unhealed, perforated drum.
   d. Boating, pioneering and hiking should always be with others of normal hearing.
2. Only for children who are deaf
   a. Dramatics may be presented in pantomime.
   b. Dancing may be accomplished by placing musical instruments on the dance floor so that the child feels the vibrations.

Prosthetic Appliances. This section is applicable to the hard of hearing child. If a hearing aid is used, the child should bring a supply of batteries which should be kept in a cool, dry place. Encouragement but not force should be used to make the child wear the aid. He may find it cumbersome in athletics or dancing.

ORTHOPEDIC

An orthopedically handicapped child is ready to go to a camp for physically normal children when he is prepared to take care of his ordinary needs, knows and accepts his limitations, and has learned how to take care of his appliance. This means that he is physically able to dress himself, attend to his toilet needs, and put on or take off the appliance he may be wearing; *i. e.*, brace, artificial limb, or other appliance.

Orthopedic diagnosis should be secured. The functional limitation is not a diagnosis.

If the camp site and equipment is such that in the pursuit of daily camp experience it is necessary to have the ability or agility to climb hills, cover rocky ground, only those children who can manage such terrain should be accepted.

The orthopedically handicapped are:

1. Post-Poliomyelitis

The child with little residual handicap requiring prosthetic appliance, *i. e.*, brace, crutches, or cane—or who walks with limp, wears special orthopedic shoes or has some limitation of shoulder or arm movement, could be integrated into regular camp program if terrain and housing are suitable. The camp should determine in advance whether or not the child is helpless without the appliance. If the camp accepts such a child, it should be prepared to meet any emergency which arises.

In *arm and hand limitations,* the camp should know in advance whether or not the child is completely independent or needs assistance in such details as cutting food, tying his shoe laces, or other daily routine. In such cases, provision should be made ahead of time for assistance either by counsellor or another member of the group. Care should be taken to give such assistance as unobtrusively as possible. Again it is a psychological hazard to focus undue attention on the disability.

Children who have had polio within one year of camp application and have no visible crippling disability should not be included in regular camp but in a more protective situation.

2. Congenital Deformities

Dwarf with no functional disability or other malformations should not be excluded from camp for physically normal children if he has no physical disability which will prevent him from participating in total programs as described above. Acceptance by the group in spite of aesthetic handicap must be a part of the educational responsibility of the camp.

3. Osteomyelitis (Inflammation of the bone marrow)

Any child who had active osteomyelitis within the year is considered in convalescent stage and should not be included in the camp for non-handicapped children. Specialized camps for orthopedically handicapped children make arrangements for accepting these children and provide for treatment. Care should be taken to avoid injury which may result in a flare up of the disease.

4. Tuberculosis of Bone

The camp should require a recent statement from medical agency that the tuberculous condition has been cured or arrested and that the child can take part in the camp program. The camp should be assured of a record of negative chest x-ray.

5. Scoliosis (Curvature of Spine)

In these cases it is important that the camp have a medical diagnosis to determine the reason for the curvature. If curvature is due to tuberculosis refer to tuberculosis of the bone above. In other conditions, decision for acceptance of child should rest on his functional abilities.

6. Cerebral Palsy (Spastic Paralysis)

Registrars and other intake personnel should be warned against excluding a cerebral palsied child on the basis of first impression and physical appearance. Consideration should be given to actual successful experiences. The only question involved is, can he participate in the camp program without the necessity of altering the physical setup of the camp situation. A well trained and well adjusted cerebral palsied child can manage daily routines adequately, provided he is permitted the same right, as any other child. In a good camp, allowance is made for individual differences and deviation in speed, motor coordination ability, character of speech, special abilities and interests.

Camp Program. Functionally, if the above specific considerations are observed, the orthopedically handicapped child should be able to participate in all activities that do not involve strenuous use of the part involved, *i. e.*, a child with involvement of the right arm might well be able to go on a hike or swimming, but would not be able to participate in boating activities which would require him to row a boat.

Prosthetic Appliances. The orthopedically handicapped child's need for constant use of appliances should be known in advance. A statement should be on file in the camp office as to the proper use of the appliance, *e. g.*, when the child needs to wear it. If he is wearing an appliance, the camp nurse should inspect both the appliance and the condition of the skin at frequent intervals.

Assurances should be given by the sending agency that equipment is in good condition at the time the child goes to camp.

VISUALLY HANDICAPPED

These children are not blind, but because of visual limitations they must conserve their vision in school, at home, and in play.

The visually handicapped group includes the sight conservation group and those who are in regular sighted classes but have a visual limitation. These children should go to a camp for physically normal children.

A statement regarding the class the child attends, such as sight conservation, braille, normally sighted, or ungraded should accompany record.

The camp nurse or physician should have complete details regarding each child's eye condition.

The eye card should contain the following information:

1. Date of examination
2. Name of ophthalmologist
3. Diagnosis of each eye
4. Visual acuity without and with correction
5. Play limitations
6. A statement as to whether the child should wear glasses constantly
7. Prescription for eye glasses or 2 pair of glasses

The doctor who makes the general physical examination should state that eyes are free from conjunctivitis. The eye examination should be within six months to one year prior to going to camp.

Physical Setup. All cases should be considered individually. Very rocky and hilly terrain should be avoided. The housing arrangements should be simple and furniture out of the way. Projecting arms or parts of furniture should not be on the eye level of children. Visually handicapped children are to be in the front line of activities. There should be adequate lighting for all activities. In case of an eye accident, child should be referred immediately to a physician.

Camp Program. Children with moderate, high, or progressive myopia (nearsighted) should avoid high jumping, bending, lifting, hiking over hilly terrain, or any other strenuous exercise. Diving, swimming in deep water or swimming for great distances from shore are not advised. The eyeball in a myopic eye is longer than in the normal eye and, therefore, the image falls too short of the retina. The supporting coats of the eye lack the normal resistance and the retina may become stretched and torn, like a piece of old elastic after much use.

Singing, folk dancing, clay modeling, freehand drawing and painting are especially good for this group. Reading, sewing, and fine-line drawing should be avoided by the whole group.

Summary

Camps for the handicapped fall into two categories: (1) Those which accept only children with a specific handicap, *i. e.*, the segregated camp. (2) Those which accept children with a handicap along with unhandicapped children as regular campers and the handicapped children participate as fully as possible in all phases of the camp program.

Physically handicapped children fall into two corresponding groups in relation to camping:

1. Those whose handicaps are of such a nature as to require the special care available in the segregated camp. In this group fall most of the diabetics; all the cardiacs not classified as IA, potential heart disease, or possible heart disease; and all epileptics not specifically certified for camp by specialists in this field. Also included are those orthopedically handicapped children unable to dress and undress themselves, attend to their toilet needs, and put on or take off the appliances they may be wearing.

2. Those capable of adjusting, within reasonable limits, to regular camp life. In this class fall practically all of the hard-of-hearing, the deaf and the visually handicapped (this does not include the blind); a considerable proportion of the orthopedically handicapped; a limited number of cardiacs and epileptics and a very few diabetics.

These two groups are not fixed. Campers in the first group constantly improve to a point where they no longer need special care. Now and then a child who has been able to adjust satisfactorily to the regular camp, must again due to physical changes return to the specialized camp.

A regular camp which accepts the handicapped must fully accept them. That is, they must live, eat, work and play on equal terms with the other children. They must not be segregated. Although no unusual provision is needed for them, the administrative staff and counsellors should be familiar with their condition and alert to their needs.

It is not advisable to accept cardiac, epileptic, or diabetic children in a camp that does not have a resident physician.

Finally, it should never be forgotten that successful camping for the handicapped is primarily a cooperative job in which the camp, the sending agency, and the physician or clinic all have a necessary part.

Camper record forms set up to include items which would make them usable for both the handicapped and nonhandicapped campers may be obtained from the Children's Welfare Federation, 435 Ninth Avenue, New York, N. Y.

The Health Officer's Job

By JOHN A. KAHL, M.D.

SOUND ADMINISTRATION in the field of public health is a paramount necessity today because public health is big business and will continue to grow bigger. The definition of public health as "the art and science of preventing disease, prolonging life, increasing physical and mental efficiency, through organized community effort" (C.-E. A. Winslow) defines our responsibilities in this respect and places emphasis where it is needed on *organized community effort.*

In order to have a successful public health program we must not only have the assistance and cooperation of the local official and non-official health agencies, but of groups and individuals within the community. The public must understand the value of public health to each individual and to the entire community. The interpretation of the program to those who support it is too often forgotten by the local health department in its effort to render a large volume of service to the community.

COLLECTING THE FACTS

If we are to enlist the cooperation and assistance of the community, we must find out what the community's health problems are and how they can be met. A logical approach is to know something of the past history of the community in which we are working. Is it made up of conservative elements or is it extremely liberal? What factors have brought this about? This information may offer some understanding of the community's reaction and attitude toward many subjects, health included. The proper psychological approach must be made to the community, or many worthwhile plans are apt to fail.

We need to know the composition of the population as to age, sex, and race. These facts will suggest the susceptibility of the population to certain diseases and indicate what protective measures should be instituted. Customs practiced by various races and nationalities are likewise of significance because on occasion they may be conducive to the spread of disease.

The occupations of the people will have bearing on the health program. The type, size, and stability of industries give us some indication of the potential health hazards and dangers to the community.

We must know something about the topography of the area, its geology, fertility of the soil, temperature ranges, humidity and rainfall. Such factors may have significance with relation to the distribution of the population over the area as well as the character of the diseases which may be prevalent.

Very important to the health program is the economic status of the community. It indicates the ability of the people to provide the necessary finances for public health. It has further significance, for if the income level is high, we know that the individual can do for himself the things that sound public health dictates, many of which cost money. There are a number of ways of evaluating the economic status of a community, but perhaps the most useful are determining the assessed valuation per capita, the expendable wealth per capita, the percent of the population owning their own homes and businesses, and the percent of the population who pay an income tax.

Last but not least, we must know the leading causes of morbidity and mortality for the area, and more specifically, the leading causes of morbidity and mortality from communicable diseases. Do any of the illnesses attack primarily specific age groups, nationalities, races or other segments of the population? The prevention of mortality is our first responsibility and these statistics will often point to our most urgent problem. The control of morbidity is a fundamental necessity

Dr. Kahl is assistant director of health in charge of local health services, State Department of Health, Seattle, Washington.

if we are to prevent mortality and at the same time improve the general health of the population.

Because the improvement in the health of a community must be accomplished through organized effort, we must list for each community the facilities available to assist the health department in successfully attacking the problems. The list will include not only health and welfare agencies but individuals with scientific and technical training: the number of physicians available and those in specialized fields, dentists, public health and other nurses, bacteriologists, and engineers. How many hospitals are there in the community, what is their total bed capacity, what facilities and services do they offer?

THE NEXT STEPS

Once we have gathered this information and set it down in orderly fashion, it becomes a matter of determining which problem or problems shall have preference. If we think in terms of mortality and morbidity, then we will think primarily in terms of illness and its causes. What do we know about the epidemiology or causes of the illnesses to which we are going to give first attention?

Our epidemiological information shows us a "chain of events" which organisms follow in order to produce disease. We will readily recognize those diseases for which we have sufficient scientific knowledge to break the chain or cycle of events. This is the fundamental principle upon which much of our preventive program is based and on which health progress to date has been made.

Assuming we understand the epidemiology of a disease sufficiently, we must ask, do we have practical measures for breaking this so-called cycle that can be applied on a mass basis to our community? If we have, then it is a matter of organizing community resources to put them into action by utilizing to the maximum all community resources available, and by educating selected groups (or the population at large depending on the nature of the disease) on how to make use of the control measures.

We have found through years of experience that the development of a "community health committee" or council with representation from professional groups, and other official and voluntary agencies able to participate in some phase of health work, is an effective means of mobilizing the community. This committee or council must also have representation from the public at large. Such an organization if properly used will make possible the integration of all health services available within the community, thereby preventing duplication, conflicts, competition, and many misunderstandings. In order to use such a council the health officer must be prepared to spend considerable time and energy in clearly defining the community's problems, and in pointing out how each of the various health agencies can participate in meeting their part of the preventive program.

The council, likewise, spreads a certain amount of public health education because each of its members represents organizations or segments of the population which in turn will learn of the local health problems. The council may have subcommittees, as for instance one composed of physicians to consider medical phases of the program, one dealing with the specific aspects of tuberculosis, venereal diseases, maternal and child hygiene, or cancer. A very useful subcommittee would be one on public education, with representation from newspapers, radio stations, schools, salesmen, or others who have had valuable experience in the ways of presenting plans of action to the community so that effective action will result.

THE HEALTH DEPARTMENT'S RESPONSIBILITY

Those of us in the field of public health must remember that we are public servants. The factor of prime importance in dealing with the public is kind and courteous consideration. We must be helpful, even to the extent of assisting people beyond the stated limit of our assignment. If we do this successfully, the community will turn more and more to the health department as a place to find sound counsel and guidance, as well as expert service within its field. This attitude of helpfulness does not just occur because of the intent of each member of the staff to be useful to the community, but is the result of well planned organization within the health department. If we undertake to organize the community to meet the problems which are detrimental to its health, then certainly the agency which is the leader in this program must be well organized.

The health department must work as a unit, although it is composed of a heterogeneous group of people. The philosophies, attitudes and interests differ for each of the groups (doctors, nurses, sanitarians, engineers, et cetera). To mold people with such varying backgrounds into a forceful, smoothly functioning organization requires skillful leadership on the part of the health officer. If he is to provide this leadership successfully, he must be well grounded in the field of general medicine, preventive medicine, sanitation, nursing, bacteriology, political science, and public relations. He must be genuinely interested in each of these fields.

There is nothing which will bring about unity of action so rapidly as joint planning. Good group planning will call for the utilization of all the specialists on the staff, each contributing his part in the overall plan. I am sorry to say that too often this joint planning is sadly neglected. How many of our local health departments hold routine well planned general staff meetings? Too frequently they say that the pressure of work is so great that there is not time to carry on this important function. Again, you hear the sanitarians, the clerks, or bacteriologists say that they gain little from a general staff meeting. I need not emphasize the fallacy of such thinking *if the meeting is planned with the interests of all in mind.*

The general staff meeting should fundamentally provide for two things:

First, it should provide for program planning and policy development. Here the public health administrator is utilizing the abilities of his entire staff in developing programs which are bound to be more sound and practical as a result of group thinking. He is also building a sense of staff unity and shared ownership in the health department program. This is bound to make for better staff morale.

Second, it should provide an opportunity for the education of the staff. Education should take the form of in-service training and should provide an opportunity for bringing in other agencies and other groups in the community to discuss their problems and present their views concerning the development of the community program. Such participation broadens the staff's understanding and approach to the people they serve.

Another sadly neglected step in planning is the provision of the planned programs and policies *in written form,* and the constant referral to them by the staff. In working with other health agencies in the community, the plans and policies should also be in writing. The staff can then refresh their memories as to the programs developed within their own department and their relationship to those of the other health agencies.

Local health departments require a more realistic approach to the matter of records and statistics. We must plan our program primarily on the basis of sound yardsticks. One of these is adequate records, which, upon study and analysis, will indicate to the administrator whether a program is accomplishing the purpose for which it set up. In the State of Washington, we have developed a State Record Manual, which is used to make it possible for us to compare from the state level the activities of local health departments, and, of more importance, to provide a tool by which a local health department can measure the effectiveness of its own program. Many public health people feel that the keeping of records is a waste of professional time. Such a statement can be readily refuted if we look at private business. Very detailed records are kept so that executives can know the status of their business at any time. If private enterprise can afford to spend large sums of money in keeping adequate records to make their business more profitable, then certainly we in public health can take a lesson from them. Adequate records are the instruments with which you measure the success or failure of a public health program. In many instances, these are the only facts which will give the health officer a total picture of the progress of his program. Records must be so planned as to measure the effectiveness of the program in terms of its goal.

Recognizing the importance of adequate records and their utilization, we have employed for the last two years a full-time "general advisory clerk" whose responsibility is to visit the local health departments and assist them in keeping better records, in using them more effectively, and in better assignment of clerical help to relieve professional personnel whenever possible. We have found the clerk may be one of the least effective members of the local health department prin-

cipally because she does not have adequate instruction and guidance in her job. Local health officers have told me on many occasions that the services of this advisory clerk have been one of the most useful services the State Department of Health has had to offer. With proper utilization of the records the health officer is able to give a better type of service to the community, to gather valuable statistical material for the evaluation of his progress and for use in the health education program.

There are minor administrative problems which are given little thought, but which often disrupt to a major degree the efficient functioning of a health department. The failure to route to the entire staff memoranda received from the State Department of Health and other agencies is often neglected. Are letters approved by the health officer, does he sign the correspondence, or does each individual interpret the policies of the department as he sees fit and sign the letters? At times very embarrassing situations have resulted from lack of clearcut policies. An office record of the field itinerary of each individual during the day is important. If an individual cannot be located and the office does not know where he or she is, certainly the public may wonder whether anyone in the department knows what is going on. The health administrator should make certain that the secretary knows how to answer the telephone, how to be courteous and helpful, and how to see that calls for individuals in the department are followed through to satisfactory completion.

THE STATE AND LOCAL HEALTH DEPARTMENT

The problem of planning with, advising and guiding local health departments through state consultants in an organized manner is not a simple problem for the administrator on the state level. Public health has grown by leaps and bounds as we all know, and developed rapidly with more and more consultants limiting their work to specialized fields.

There must be some coordinated and concerted planning in rendering service to local health departments if we wish to avoid a chaotic condition resulting from numbers of state consultants visiting local health departments. The recommendations made by the various consultants must be so coordinated that they dovetail into a sound plan which is sufficiently realistic for the local health department to carry out. This has been my problem for the past four years and we have attempted to develop plans to provide the necessary consultation service and, at the same time, permit each of the special programs to develop to their fullest extent in the least possible time.

In the State of Washington, we devised a plan for all of the consultants to submit monthly travel itineraries to the Division of Local Health Service in order to avoid any conflicts in field schedules of state consultants, and to obtain a pattern of consultation service rendered in the state. We also wanted to avoid too frequent visits to the departments along the better highways of the state and to distribute the services more evenly.

In order to prevent conflicts in recommendations of the various consultants and to avoid competitive bidding for the time of local personnel we have a three-point plan:

1. We developed the Record Manual to standardize the pertinent and essential information necessary for the local health department to render good service, and we developed methods for handling this information within the local health department.

2. We are preparing a "program and procedure book" in which we hope to set forth the underlying principles in each of the many programs to be developed in local areas. This should bring about more coordination of recommendations since specialists will interpret these general procedures and programs within their field and assist in their development through their specialized ability.

Let me emphasize that such an undertaking cannot be successful without adequate participation of the local health departments in planning. In the development of our Record Manual, much assistance was received through a committee from the State Health Officers Organization, who in turn sought the advice and guidance of their nursing, sanitation, and other groups. Because of this joint planning, the Record Manual has been well received.

3. Each consultant, after visiting a local health department, makes a field report stating dates of visit, purpose of the visit, findings and recommendations. This report is addressed to the local health officer, one copy retained in the consultant's division or section, and an additional copy submitted to the Division of Local Health Service. This procedure results in careful analysis by the consultant of the problem and more realistic recommendations. It places on permanent record the findings of the visit and the recommendations for future study and use by the local health department personnel. It informs the Division of Local Health Services in the State Department of Health of the content of the visit and the recommendations.

In order to make the information contained in field reports available to the entire consulting staff of the state, we maintain what is known as a "current field file" for each local department. This file is just what it says—"current." When a follow-up visit is made, the old field report is pulled out and the more recent one replaces it. Consultants going into a specific local health department are required to come to the Division of Local Health Services and read the field reports. The procedure gives each consultant going to the area a total picture of the most recent recommendations and plans concerning each of the programs in the department, and further, prepares the consultant to make recommendations which will not be in conflict with those previously made, but will promote the total program.

Another phase of improving consultation services to local health departments is gradually being brought about by lengthening the stay of the consultant in the local health department. Under such a plan we will decrease the frequency of visits but some of our local health departments feel this will be a real advantage as they have had too many consultants visiting them and have not been able to utilize the consultant's time wisely. We are also encouraging our state consultants to make a tentative date for a return visit if indicated. We still have the important problem of general consultation versus specialized consultation on a routine basis. It is an accepted principle that we encourage local health departments to develop their program on a generalized basis and to use as few specialized personnel as possible. It seems to me, therefore, only logical that in the utilization of consultants to evaluate generalized programs we need to use more generalized state consultants, holding the specialized consultants in reserve for use in their particular field after the need has been determined.

In all our planning we use what we call the "joint state planning committee," which is composed of all of the division chiefs and section heads in the State Department of Health, who meet with the Division of Local Health Services to go over data, carefully evaluate it, and set down recommendations. The Division of Local Health Services then approaches the health officer to obtain his comments, criticism, and recommendations which are brought back again to the State Department of Health for review. The local health officer is requested to be present at this meeting in order to present his views.

The plan while new and subject to revision has already had one important value not recognized in the beginning. It has made our division chiefs and section heads appreciate the scope of a total local public health program and the part that their particular division or section plays in it. It also has the advantage of placing the Division of Local Health Service in the essential and necessary position where both the local health department and the state consultants look to it as the balance wheel of local health services. This in my opinion is fundamental if we are to build soundly the big business of modern public health.

Presented by Dr. Kahl at the Health Officers and Sanitarians Joint Conference, Portland, Oregon, February 7, 1946.

TWO HUNDRED and thirty-three Army and Navy nurses who gave their lives in World War II have been awarded posthumously the Bronze Medal of the American Red Cross in recognition of their service. The awards were presented to the next of kin of those nurses reported by the Army and Navy as having died in line of duty. More than 100,000 nurses volunteered for military—representing 43 percent of the total graduate nurse population, a higher percentage of volunteers than for any other professional group.

Gamma Globulin in Measles Prophylaxis

By MORRIS GREENBERG, M.D.

THE TREMENDOUS contribution of blood plasma to the armed forces made by the American public is too well known to require comment. Blood plasma is a complicated substance and the task was assigned by the Committee on Medical Research to Dr. E. J. Cohn and his collaborators at Harvard University to determine how the various fractions of blood plasma could be separated for more economical use. By the use of physical chemical methods, Dr. Cohn and his group were able to separate blood plasma into 6 fractions. One of these fractions contained albumin. Since this protein is the most important part of plasma for use in the treatment of shock due to burns, injuries, and hemorrhage, it was much more economical and effective to send albumin to the armed forces rather than whole plasma. This left the 5 remaining fractions of plasma as a sort of waste product. The Harvard group began investigations to determine what medical use could be made of the various proteins concentrated in this waste product.

One of the proteins left in plasma after the albumin is removed is globulin. There are 3 types of globulin, alpha, beta, and gamma, each of which has a different physiological function. It had been known for some time that the antibodies in blood are concentrated in the gamma globulin. Actual tests showed that the gamma globulin contained antibodies against most of the infectious diseases. When a child has measles, it develops a permanent immunity against the disease. This is due to the fact that measles antibodies develop in the child's body and remain there permanently. They are present in the blood and are concentrated in the gamma globulin of the plasma. About 90 percent of all adults in the United States have had measles. Blood collected from a cross section of the population should, therefore, have large amounts of measles antibody in it. Since gamma globulin is a 25-fold concentration of plasma, the amount of measles antibody in this fraction should theoretically be large, and small amounts should protect children exposed to measles.

An actual field trial to determine the value of gamma globulin in measles prophylaxis was undertaken by the New York City Department of Health[1] in 1944. Gamma globulin was injected into more than 800 children who were known not to have had measles previously, and who were contacts to a case of measles in their own family. They were between the ages of 6 months and 6 years. A uniform dose of 2 cc. of gamma globulin was injected intramuscularly. The injections were given on different days of exposure, but most of the children were treated between the fourth and eighth day after exposure. Since most cases of measles develop the rash on the third or fourth day after onset of the disease, this means that the contacts were usually injected between the day when the rash first appeared in the source case and 4 days thereafter. The children were carefully followed for the next 3 weeks by regular visits to their homes by a physician attached to the Department.

The results were very gratifying. About 79 percent of the injected children developed no measles. The remainder developed modified measles. In most of these the disease was so attenuated that if the children had not been regularly inspected, the occurrence of the disease might have been missed. This is quite different from the usual occurrence of the disease, with high fever, severe cough, marked nasal and eye discharges, and great discomfort. No cases of regular measles occurred in the injected group.

When the results were analyzed according to the day on which the injection was given,

Dr. Greenberg is epidemiologist, New York City Department of Health, and instructor in epidemiology, Columbia University, New York.

there appeared to be little difference so long as the injection was given between the fourth and eighth days after initial exposure. An analysis of the data according to age indicated that the younger children got more complete protection than the older ones. Thus, 90 percent of infants from 9 to 12 months of age were completely protected as contrasted with 80 percent at age 1, 78 percent at age 2, 71 percent at age 3, 64 percent at age 4, and 61 percent at age 5. This would indicate that protection or modification depends on the amount used per pound of body weight. Actually, in two other investigations carried out by others, one in Philadelphia[2] and the other in Boston,[3] a dose of 0.1 cc. per pound of body weight was used when it was desired to protect completely, and a quarter of this dose when it was desired to give the contact modified measles. Since measles is most serious and has its greatest mortality in the very young, it is advisable to protect them completely; the older children may be allowed to have modified measles. A dose of 2 cc. answers both needs. It will give complete protection to a very high percentage of the youngest susceptible infants and will cause modification in an increasing percentage with the rise in the child's age. For this reason, the New York City Health Department advises a uniform dose of 2 cc. for all contacts. Infants under 6 months of age possess immunity which they have inherited from their mothers and need not be inoculated even if exposed to measles.

Two other substances have been used in recent years for the prophylaxis of measles. One of these is convalescent measles serum. This confers a high degree of immunity but it is not readily available and must be used in large quantities. The other substance is placental globulin. It is a mixture of globulins prepared by chemical means from the blood expressed from placentae. It has two disadvantages: first, about 23 percent of injected children are not at all protected, but develop the usual form of measles; second, the injection causes severe reactions, local and general, in about 40 percent of the cases. Incidentally, placental globulin is marketed as "immune globulin—human" and should not be confused with gamma globulin, which is "human immune *serum* globulin."

Injections of gamma globulin do not cause local or general reactions. Also, one need not be afraid to give it to a child with allergy, since the material comes from human blood and causes no allergic manifestations.

Public health nurses should understand that the immunity conferred by gamma globulin is a passive immunity, similar to the immunity conferred by diphtheria or tetanus antitoxin. Such immunity is temporary and usually lasts only about 2 to 3 weeks, after which the individual again becomes susceptible. It is to be differentiated from such substances as diphtheria toxoid or pertussis vaccine, which confer an active immunity which lasts a considerable period of time, usually measured in years. There is at present no known substance which confers active immunity against measles.

Parents occasionally request to have their children immunized with gamma globulin although they have not been exposed to measles, and do not understand why such a request is refused. The public health nurse should explain to the parents that the immunity is short lived. Measles usually occurs in the winter and spring. To keep a child immune it would have to be injected every 3 weeks during these seasons. This is obviously an impractical procedure. When and if a substance is found which will give active immunity against measles, its use will be recommended for all children during the first year, just as diphtheria toxoid is recommended now. Until such a substance is found, gamma globulin should be used only when a susceptible child is exposed to a case of measles.

The public health nurse may also be asked by parents why exposed children are given modifying doses of gamma globulin rather than protective doses. The reason is that such a dose causes a mild attack of measles in the child. There is evidence to believe that such a mild attack confers permanent immunity just as a severe attack does. A child having a mild attack will therefore be reasonably certain that he will not get measles again. If the dose of gamma globulin protects him completely, however, he will again be susceptible to measles if exposed to the disease after a few weeks.

SUMMARY

1. Gamma globulin, a protein obtained from human blood plasma, is the substance of choice in the prevention or modification of measles.

2. Gamma globulin confers a passive immunity. Such immunity lasts only about three weeks. Children should therefore be injected only when exposed to measles.

3. Measles is most serious in the youngest age group. It is therefore desirable to protect this group completely. The older child should be given a dose which will permit it to get a modified form of measles; this will enable the child to develop an active immunity against the disease, and thus become permanently immune. A dose of 2 cc. fulfills both needs and is recommended for all ages above 6 months. Infants under 6 months need not be injected, since they still retain immunity inherited from the mother.

4. Local and general reactions from the injection are negligible. Allergic reactions do not occur, since gamma globulin is obtained from human blood.

REFERENCES

[1]Greenberg, Morris, Frant, Samuel and Rutstein, David D. "'Gamma Globulin' and 'Placental Globulin.'" *Journal of the American Medical Association*, December 9, 1944, p. 944.

[2]Stokes, J. Jr., Maris, E. P., and Gellis, S. S. "Use of Concentrated Normal Human Serum Gamma Globulin (Human Immune Serum Globulin) in the Prophylaxis and Treatment of Measles." *Journal of Clinical Investigation*, July 1944, p. 531.

[3]Ordman, C. W., Jennings, C. G., and Janeway, C A. "The Use of Concentrated Normal Human Serum Gamma Globulin (Human Immune Serum Globulin) in the Prevention and Attenuation of Measles." *Journal of Clinical Investigation*, July 1944, p. 541.

Attention—School Nurses and Administrators

THE EDITORS of the Magazine have given heed to the many reports that a school nursing issue published in September comes too late for school personnel to use in planning for the current year. This year, particularly because of the fall Biennial, the special school issue is postponed until the following spring—April 1947. However, the policy of carrying each month articles pointed specifically and others of general interest to nurses in the school health field will be continued. For example, this year the Magazine has published such articles as: "School Health: Whose Job Is It?" by Charles Brake and "Public Health Nurse in the Rural School" by Margaret Maxwell (February) and "Opportunities for Eye Health" (April). Of interest to the school nurse also was "Public Health Nursing Salaries, 1945" in March. "Suggested School Health Policies" (in 3 installments) was concluded in January, and reprints are now available, free in single copies to members, and 20 cents per copy to nonmembers.

School nurses will be interested in the renewed letterbox section in the Magazine, "Our Readers Say," which returned with new zest and hope for a stimulating career, in May. There are many controversial issues in the field of school health, and the participation of school nurses is urgently requested.

Finally, the editors, as always, are anxious to receive suggestions from the field as to articles which would be of help and interest to the school nurse group and will welcome heartily any such articles submitted for consideration.

Let your Magazine be of greater help to you.

Rheumatic Fever: Etiology, Epidemiology, and Prevalence

By ARNOLD G. WEDUM, M.D.

RHEUMATIC FEVER is rapidly becoming known as the first cause of death in the United States among children 10 to 14 years of age. Indeed, in some states it is the most important cause of death for the entire age group 5 to 19.[1]

Rheumatic fever may take several forms, some of which are difficult to recognize. The most obvious signs are joint pain, joint swelling, and St. Vitus dance or chorea. These manifestations are unimportant in themselves. They disappear with treatment and leave no residual difficulty. But heart disease which may appear with these signs or entirely by itself, or in some children not at all, is the important thing. The disease "licks the joint and bites the heart." The children and young adults die of heart failure.

The importance of this disease in the United States has emerged as deaths from diphtheria, scarlet fever, typhoid fever, pneumonia, and tuberculosis have subsided. Rheumatic fever is not a new disease. It has been one of mankind's afflictions for centuries. But up to recent times there have been many greater scourges. As these scourges are being conquered through preventive medicine and advances in medical treatment, rheumatic fever has remained largely untouched, with its etiology, diagnosis, and specific treatment still shrouded in uncertainty.

ETIOLOGY

The cause of this disease is unknown. As might be expected in such a case, there are a variety of theories.[2] The two leading ones are:

1. Rheumatic fever is the result of allergic hypersensitivity.
2. Rheumatic fever is caused by a virus.

Both theories involve the hemolytic streptococcus.

In the former, it is thought that the body may become hypersensitive (as a patient does to ragweed pollen in hayfever) to the streptococcus or its products, to the streptococcus plus something from the body, or to something the body makes in response to the organism (autoantigen).

In the latter theory, it is thought that a virus phase of the streptococcus is involved, or a new yet unknown virus. In either case, a streptococcal infection such as a sore throat or scarlet fever may act as a trigger mechanism which sets off the charge of virus so that it injures the body.

The concept that the streptococcus acts as a trigger mechanism proceeds from the clinical observation that the rheumatic episode develops in three stages: (1) Phase I comprises a relatively mild streptococcal infection (2) Phase II is a quiescent period lasting from 7 to 14 days, the patient is apparently well and (3) Phase III is acute rheumatic fever.

Rarely some other condition such as dysentery, sandfly fever, malaria,[3] tonsillectomy, trauma, or protein shock may occur in Phase I instead of infection with the streptococcus.

EPIDEMIOLOGY

Streptococcal Infections. Four to 5 percent of children aged 5 to 19 who have streptococcal infections develop rheumatic fever. Does this mean that this percentage of all children will develop the disease, as all are exposed to streptococcal infections? Actually, when a large number of children are ex-

Dr. Wedum is assistant professor of bacteriology, University of Colorado School of Medicine, Denver. Present address: Camp Detrick, Frederick, Md.

amined about 2 percent show signs of heart disease and about 2 percent are potential cases (a history of rheumatic fever) or possible cases (doubtful heart findings). This applies to most northern and eastern states, but not to regions with year-round warm climates.[1]

Recurrences. Suppose a child has recovered from an attack. What chance has he of having another? If he has another streptococcal infection, the chance of recurrence of rheumatic fever is about 50 percent. A cold causes recurrence in about 33 percent. With each recurrence the heart is further damaged. One should prevent respiratory infections among rheumatic children, possibly by sulfonamide prophylaxis for individuals, use of a separate bed for such a child in the home, and measures to minimize cross infections in convalescent homes. School administrators, physicians, nurses, and teachers have an important responsibility to establish a system whereby children with colds and sore throats are excluded from school. The system should include education of parents to keep children with sore throats and colds at home.

Age. Rheumatic fever most frequently begins at age 7. Is this because a new group is entering school, freshly susceptible to streptococcal infections? In military camps the rheumatic fever rate drops when new recruits are not admitted. Children have the further disadvantage of immature immune mechanisms and body structures. Puberty lessens recurrence and tends to a more benign type of rheumatic fever.

Heredity. There is no inheritance of rheumatic fever but there is a hereditary susceptibility. When neither parent has had the disease there is less chance of the children acquiring it than if one or both of the parents have had it.

Climate. A warm dry climate is associated with fewer respiratory infections and therefore reduces recurrences. The climate itself is not curative. It is a mistake for a patient with rheumatic fever to go to such a place as Arizona, for instance, unless good living conditions and good medical care can be obtained.

Environment. Recent experience in military camps in the United States has shown that certain factors such as rats, fleas, dietary deficiencies, and poverty are not essential to production of rheumatic fever, even though they are closely associated with it in civilian life. Although the disease does occur in well-to-do families, it is more frequent in the poor.

Common to both the military man and to the poor civilian are (1) cold, dampness, and fatigue and (2) crowding. Crowding aids spread of respiratory infections which precede rheumatic fever. Practical points to consider are that the number of persons per room is more important than the floor space per person, that it is best to have only 6 to 8 children in a room in a convalescent home, and that hospitals caring for such children should consider measures to minimize the amount of dust and bacteria carried by air currents.

PREVALENCE

Mortality statistics show that the greatest prevalence is in the northeastern states and in the Rocky Mountain area.

Of more interest to the nursing profession is that we can expect in northern latitudes about 2 percent of our children between the ages 5 and 19 to have signs of heart disease and about 2 percent to have potential or possible heart disease following rheumatic fever. Of those children who are sick enough to require hospital care, 25 percent will die within 10 years. Of those who survive, many die at the age of 29 to 46,[4] unfortunately just as these adults are well established in the responsibilities of marriage and business. Many of these deaths in later life represent the penalty for failure to secure during childhood proper convalescent care, direction of physical activities, and vocational guidance.

If we think in terms of the case load of a public health nurse, she can expect about 2 new cases of acute rheumatic fever each year per 1,000 children aged 5 to 19.[5] Even if these children are cared for in a hospital during the acute stage, during convalescence a public health nurse can be of great help to a mother harrassed by the problem of providing occupational therapy and prolonged nursing care. This period of home nursing is a critical one. Upon it often depends whether or not the child will sustain permanent injury to the heart. The nurse usually must do more than make routine visits. Only extra effort will provide good nursing care, occupational therapy to keep the child inter-

ested and amused, home teaching so he will not become apprehensive about falling behind his class in school, proper nutrition, vocational training, psychiatric adjustment in the home, and conscientious supervision by a physician. When she can help accomplish all this, the public health nurse can assume a large share of credit for changing the rheumatic patient from a potential cripple into a healthy child.

REFERENCES

[1]Wedum, Bernice G., Wedum, A. G., and Beaghler, A. L. "Prevalence of Rheumatic Heart Disease in Denver School Children." *American Journal of Public Health,* December 1945, p. 1271.

[2]Jones, T. Duckett. "The Etiology of Rheumatic Fever." *Journal of Pediatrics,* December 1939, p. 772.

[3]Copeman, W. S. C. "Observations on the Natural History of Acute Rheumatic Fever." *Journal of the American Medical Association,* January 6, 1945, p. 30.

[4]Wedum, A. G., and Wedum, Bernice G. "Rheumatic Infections in Cincinnati Hospitals." *American Journal of Diseases of Children,* March 1944, p. 182.

[5]Paul, J. R. The Epidemiology of Rheumatic Fever and Some of Its Public Health Aspects. Published for the American Heart Association by the Metropolitan Life Insurance Company, second edition 1943.

Something Different

PUBLIC HEALTH NURSES, how about speeding up and flying with the times! Use an airplane as a symbol in striving for health and efficiency. Compare your patient with an airplane. It will please the mothers and intrigue the children.

	Prenatal and Infant	*Preschool and School*
Overall length	Height	Height
Wing spread	Weight	Weight
Wing loading	Food	Food
Fuselage covering	Healthy skin	Healthy skin
Galley equipment	Bottles and nipples	Sanitary kitchen
Radio equipment	Crying*	Universal wave length and unlimited power**
Engine	2 lunger (1 B.P.—Baby Power)	Children's 2 lunger, in good running order

*Note: Emergency only, V.H.F. (very high frequency)
**Note: Station N.V. (normal voice)

—LOUISE SITZENSTOCK, R.N., *Oakland, California*

First Principles in Building a Tuberculosis Service

By HORTENSE HILBERT, R.N.

SINCE THE QUALITY of tuberculosis nursing depends so largely upon the adequacy in amount and kind of general public health nursing in the community, I should like to touch upon some of the principal factors that combine to produce a unit of satisfactory service.

The public health nursing aspects of tuberculosis control are generally agreed to consist chiefly in assistance in locating persons having tuberculosis; bringing them and their families promptly into contact with appropriate diagnostic and treatment resources; and helping with the patients' aftercare and rehabilitation. It follows that public health nursing is a valuable asset to the tuberculosis control program to the degree that it is developed as a communitywide family service given by thoroughly qualified public health nurses.

A general family health service which includes services for various types of health conditions and all age groups gives the public health nurse entree into many families and homes, perhaps a more natural entree than that of the more specialized worker who gives attention to only a single health condition or age group.

The general public health nurse's work in other locations, such as elementary and high schools, child care centers, industrial plants, child health stations, also is significant in connection with tuberculosis control.

Of the several components involved in developing a service which will meet the needs of the community, some are organizational and administrative; others educational and personal. All are interdependent. In the expert ordering and blending of the various components lies the answer to a good public health nursing service.

Miss Hilbert is director, Bureau of Nursing, New York City Department of Healt

EDUCATIONAL QUALIFICATIONS OF PERSONNEL

Fundamental to subsequent competence in public health nursing is a sound basic nursing education obtainable in a school of nursing which offers broad experience in the various clinical branches and which has regard for the educational values to the student nurse as well as to what she contributes practically to the operation of the hospital.

Most hospitals with which schools of nursing are connected do not offer much, if any, experience in tuberculosis nursing since tuberculous patients are usually cared for in special hospitals having no affiliation with schools of nursing. Utilization of these special hospitals in connection with schools of nursing would obviously be advantageous for the more complete basic education of the professional nurse. In recent years, however, reluctance to exposing young nursing students in this way has increased on the part of parents and others responsible for their welfare. Any risks we hope can be safely overcome through further study and research about effective safeguards.

The next step in the professional preparation of the public health nurse is training in the application of nursing knowledge and techniques to the field of public health, such as can be acquired through NOPHN accredited programs of study in public health nursing conducted for graduate nurses in 31 universities and colleges in various sections of the country. Through a combination of theory and field practice the public health nursing student here gains familiarity

with the control aspects of preventable communicable disease, including tuberculosis.

It may be of interest in this connection to take a look at the extent to which nurses employed for public health services in the country as a whole and in New York City in particular have this additional preparation for public health nursing.

According to the USPHS survey of qualifications of public health nurses in the United States, approximately 27 percent of some 20,000 working on January 1, 1945 had completed one or more years of an approved program of study in public health nursing.

For urban official agencies throughout the country the figure is about the same as that for voluntary agencies, namely 18 percent. But for the official public health agency of New York City, employing around 800 public health nurses, it is only 16 percent in contrast to 57 percent for the city's 13 voluntary agencies employing approximately 400 public health nurses. However, it must be mentioned that a sizable proportion of the local official agency-employed public health nursing staff have completed some portion of the public health nursing program of study, and many are now enrolled for courses.

For teaching and consultant positions in special fields such as tuberculosis nursing, advanced preparation in the clinical specialty is certainly needed, but has until quite recently, except in one or two teaching institutions, been difficult to secure. Through stimulus from the NOPHN and the Tuberculosis Control Division of the United States Public Health Service, several universities and public health agencies are now beginning to offer tuberculosis nursing experience on an advanced level to public health nurses in teaching or consultant capacities in schools of nursing and public health nursing services. Our own New York City Department of Health, whose tuberculosis service has so much to offer, has as an experiment within the year accepted a group of four public health nursing students for a three-months' internship. The benefits of this kind of experience still remain to be evaluated.

It goes without saying that awareness and knowledge of the social and psychological factors underlying the causes and cure of illness are essential for the public health worker of both the medical and nursing professions—an understanding which derives chiefly from a social sensitiveness and intuitiveness that some people just naturally have and others never seem to develop. Through exposure to broader cultural influences and progressive general education, however, this quality which must attach to all services to people can be further cultivated.

In passing, I should like to comment on what seems to be a revival in certain circles of the menace of the "over-educated" nurse, evidently the bête noir of the "under-educated" employer of nurses whose interest lies more in cheap service than in good care.

Certainly public health nursing of high quality cannot be cheaply provided any more than can a high quality of public health medicine. We have evidence galore that an under-done public health worker of any profession is an economy the community can ill afford.

ADMINISTRATIVE CONSIDERATIONS

This brings us to some of the administrative factors of significance in the provision of adequate public health nursing service. As we raise our sights in respect to professional education, it is clear that we also need to maintain administrative policies and practices that will attract and hold well qualified personnel, practices relating to salaries, security provisions, and other conditions of work.

There are still marked differences in personnel practices among agencies employing public health nurses for comparable types of services in our own community. Among these, salaries are a particularly striking example. For example, the official public health agency in New York City, which employs about 70 percent of all the public health nurses working in the city and is probably the largest single employer of public health nurses in the country if not in the world, has been offering a minimum basic salary of only $1,500, regardless of qualifications. This is, of course, much lower than the beginning salary of any state, federal, or voluntary agency in the same geographical area and considerably lower than salaries paid nurses for work not requiring additional preparation. As a matter of fact, it falls

below the wages paid for many types of unskilled labor.

We hope, however, that we are well on our way toward improving this situation, realizing that it is impossible under such conditions to attract the caliber of nurses we need for tuberculosis nursing or any other of the essential public health services.

The fact that the official agency operates under a merit system that offers benefits in the way of tenure for satisfactory service, retirement provisions, and other career incentives, becomes less and less significant as a compensation for inadequate salaries. Similar benefits are available in the state and federal services, and voluntary agencies, too, are beginning to provide such securities plus more adequate salaries.

In-service education or training on the job is continuously needed to keep public health nurses in a general program abreast of developments in the various fields of health service, of which tuberculosis is an important one. Agencies which have had to take on lesser qualified personnel because of inability to pay reasonably adequate salaries or because of wartime shortages, find themselves in the position of having to provide more training on the job as a substitute for preparation which should have been obtained before employment. This necessity will undoubtedly diminish as our general personnel situation improves.

General public health nursing supervisors, properly prepared through study and experience and in a liberal ratio to field nurses, as well as public health nursing consultants in the special fields, of which tuberculosis is a major one, are indispensable to the production of a satisfactory unit of public health nursing service.

Another administrative factor of importance is a close and constant liaison of public health nurses with the source of medical care—whether clinic, practicing physician, or institution. This is essential for two reasons: (1) to maintain the continuity and intensity of medical care, and the individual and family health guidance, especially important in the control of tuberculosis, and (2) to assure the scientific accuracy and reliability of content upon which nursing service and teaching are based, and for which we are dependent upon medical services.

There are of course many more elements of an administrative nature in the provision of a good public health nursing service that might be discussed in relation to tuberculosis control. Suffice it to say that administrative practices and procedures are important to the degree to which they expedite the total job; free every worker to contribute the most of what he has, with expertness, enthusiasm, and devotion; and bring together all the knowledge, training, and talent available into a harmonious, socially efficient whole.

A WORD ABOUT COMMUNITY ORGANIZATION

Just as personnel can be helped or handicapped in the performance of public health nursing by administrative policies governing their agency, so can community planning and organization facilitate or hinder the agency's efficiency and the distribution and quality of public health nursing service.

In a city as large, complex, and old as New York it is to be expected that many agencies would be involved to some extent in the administration of various kinds of public health nursing service. In addition to the nursing service of the Health Department there are a dozen or more voluntary agencies giving service—some providing a more or less general service in a single neighborhood, others serving the whole or most of the city with a special type of service. Some are primarily health agencies and others are primarily social service agencies. Although there is no doubt but that different points of view and approaches can make for a less sterile, more flexible community service, the best and fullest use of each of these numerous resources can be brought about only through closest coordination of program and personnel.

Despite the relatively generous provision of public health facilities, there are in New York City still many gaps and deficiencies in the total service to the community and to the family. This applies to tuberculosis, which is so peculiarly a family disease, as well as to other phases of the public health nursing program. How to overcome them ranks high among the community problems in public health nursing in the City of New York.

The last few years have seen some interesting developments in the closer coordina-

tion of the public health nursing service of the various agencies. For example, there is an arrangement through which the public health nurses of a specialized voluntary agency function as advisers in their special field, which happens to be orthopedics, to the general public health nurses of the official as well as another voluntary agency. This interweaving of resources undoubtedly is a pattern that has implications for other special fields such as maternity and tuberculosis.

Serious thought is also at the moment being given to experimentation with a completely generalized public health nursing service in one or two areas of the city. According to this plan all personnel giving direct service, whether official or voluntary, special or general, would constitute a single pool of general public health nurses, every nurse giving all the kinds of service needed in the family—services now divided among several public health nurses.

Experimentation and demonstrations of this kind will, we believe, give us fuller and more exact knowledge regarding economies and efficiencies of operation, and continuity and improved quality of service which may be achieved through greater unification and generalization of service. All of these developments will have value also for the tuberculosis control program.

CONCLUSION

The lessons learned during the war about the advantages of greater coordination or even combination of public health nursing services to secure a better distribution of care and to conserve personnel are during peacetime being retained or newly applied in many communities, particularly in the West where the public health nursing customs of yesterday are not quite so deeply intrenched.

Although great gains have been made in the past decade or two in the reduction of deaths from tuberculosis in New York City, tuberculosis still holds fifth place among leading causes of death. The 1944 tuberculosis death rate of 46 per 100,000 population and all it implies gives no cause for relaxing efforts in tuberculosis control.

Of significance to public health workers is the fact that the death rate from tuberculosis among Negroes in New York City is five times or more as great as among the white population, and that a very high death rate continues in certain sections of the city.

A properly organized community health service, progressively and efficiently administered, should be able to make special provision for intensification of services among population groups and in sections where they are obviously most needed. This I would think might well apply to public health nursing as well as to the clinical, medical aspects of tuberculosis control.

May I repeat that it is through a harmonious combination of educational, administrative, and community organizational factors that a good quality of public health nursing is eventually achieved. The best qualified, most competent, and conscientious personnel in the world cannot function productively when the conditions of work are hampering and frustrating. By the same token the most perfect administrative structure and machinery cannot produce a good service if those giving it are poorly qualified professionally for their jobs. And neither perfect administration nor professional qualifications can compensate wholly for lacks in social planning, community organization, and leadership.

This paper was given at the Annual Conference of the New York Tuberculosis and Health Association on March 23, 1946, in New York.

Public Health Nursing in a State Medical Care Program

By HELEN L. FISK, R.N.

THE 1945 SESSION of the General Assembly of Maryland established a Bureau of Medical Services within the State Department of Health to administer the medical care program recommended by the Medical and Chirurgical Faculty of Maryland and also to perform duties in connection with the licensing of hospitals and the administration of three chronic disease hospitals which are to be constructed.

Since the law authorizes (within the provisions of the Budget) the Bureau of Medical Services to provide bedside nursing to eligible persons, the opportunities for developing and expanding our present public health nursing services become immediately apparent.

A brief review of the origin, development, and progress to date of the medical care program will be helpful in showing the part of public health nursing in the total program.

The Medical and Chirurgical Faculty in 1939 suggested that the State Planning Commission appoint a committee on medical care to survey the problems of getting adequate care to the residents of this state. The committee was appointed, with representatives of all agencies interested in the matter officially or on a voluntary basis. The first meeting was held in January 1940. In April 1944, following field surveys and other investigations made to determine the availability of adequate care, the Maryland State Planning Commission published the committee report. It recommended, among other things, that a program of medical care for the indigent and medically indigent in the counties of Maryland be established by the State of Maryland and that the program be formulated and administered by the State Department of Health. Baltimore City was not included within the scope of the committee's recommendations although the group recognized the need for a similar program in Baltimore and urged its formation at a future date. The committee further recommended the creation of a council on medical care.

The report received the unanimous approval of the Medical and Chirurgical Faculty at its annual meeting in April 1944. The Faculty sent the report to the Governor with the request that he recommend the necessary legislation. A bill putting the plan for medical care into effect was written, passed by the State Legislature and became a Law on February 9, 1945, when it was signed by the Governor.

For the first two years an appropriation of $200,000 per year was made. It was generally felt that this amount would suffice for a beginning, especially since there was general employment at the time the bill was passed.

In accordance with the law the State Board of Health appointed a Council on Medical Care promptly and the group held its first meeting in May 1945. Members of the Council include representatives of the medical, dental, pharmaceutical, and nursing professions, hospitals, public health and welfare agencies. The Council is advisory in character, the final authority resting with the State Board of Health.

The Council recommended flexible statewide policies in order that the program might meet the local needs of the various counties. Accordingly county advisory committees on medical care have been appointed. These committees must include 3 members to be named by the county medical society, 1 member to be named by the dental society hav-

Miss Fisk is chief, Division of Public Health Nursing, State Department of Health, Baltimore.

ing jurisdiction in the county, 1 member appointed by the Maryland Pharmaceutical Association, the executive of the county welfare board, the chairman of the board of county commissioners or his delegated representative, and the county health officer who serves as chairman. Individual counties can appoint additional members at their own discretion, but it is recommended that the total number should not exceed 10. In naming additional members to the local councils, it is suggested that the county health officers choose representatives from such groups as Negroes, departments of education, nurses, local hospitals, and public health lay organizations.

Each county is required to submit an accurately and completely defined program to the Bureau of Medical Services. As of today each of the 23 counties has a program approved by the Bureau and functioning. The scope of each county's program varies. Services may include home and office care, surgery, obstetrical services, consultation, dental care, bedside nursing care, drugs, laboratory services, and clinic services. Certified clients of the public welfare department are eligible for care. Eligibility of the medically indigent is determined by the county health officer or his designated agent and is determined on the basis of medical and social factors.

IN THE 23 PROGRAMS which have been approved (Baltimore City is not included), 19 provide for bedside nursing services, given by the county health department public health nursing staff to the extent it is available. Six counties have included the services of professional nurses on a visit basis, and three have included the payment of professional nurses for critically ill patients in hospitals on a per diem basis.

For the purposes of the medical care program, bedside nursing has been defined as nursing care given to patients in their homes on a visit basis by public health nurses employed by the county health department; nursing care given by professional nurses on a visit basis under the direction of the county health department; and nursing care given by professional nurses to critically ill patients in hospitals.

For many years the public health nurses in the counties of Maryland have carried on a generalized public health nursing program. The extent to which nursing care is given as a part of the educational services of the county health departments varies widely, and is to a large degree determined by:

1. The policy of the county health department in relation to bedside nursing service administered by an official agency. Health departments have been concerned with the prevention and control of disease rather than with its treatment.

2. The use of the county health department services by the practicing physicians. The available public health nursing services of official agencies have not always been utilized.

3. The number of nurses on the staff. In many counties, although the health officers and nurses believe in and recognize the need for bedside nursing, limited staffs have prevented including it in the program.

4. The preparation and experience of the public health nurses. Nurses who have had theory and experience in public health nursing agencies giving a bedside nursing service are more aware of the opportunities for integrating nursing care with health teaching.

Any approach to or plans for the development of a program which includes nursing care of the sick as a part of the official agency program must consider the foregoing traditions, philosophy, and attitudes. Health counseling and the nursing services in relation to the control and prevention of communicable diseases have always been, and will continue to be, important functions of public health nurses employed by official agencies. Very often public health nurses have not been able to utilize opportunities for giving nursing care as a part of the educational service. When health teaching can be integrated with a service for which families recognize the need, our health teaching will begin to show results.

All the public health nursing services which are now available in the counties of Maryland, exclusive of Baltimore City, (except for the one-nurse Red Cross nursing service in one county, the Metropolitan Life Insurance nursing service available for special groups in seven counties, one school nurse employed by a department of education, one nurse employed by a welfare agency, and one by a housing area) are given by the county

health department staffs. At the present time, if all nursing personnel in the counties were evenly distributed, we would not have the ratio recommended for health departments by the Committee on Administrative Practice of the American Public Health Association of 1 public health nurse to 5,000 population, much less the ratio recommended by the National Organization for Public Health Nursing of 1 to 2,000, as necessary for a complete public health nursing program including bedside care. Thirteen counties have adequate supervisory assistance for their present staffs and programs.

HOW THEN, and to what extent, can public health nurses participate in the medical care program? Obviously our present staff, with a ratio of 1 nurse to 7,000 population and in some areas 1 nurse to 15,000 or 20,000 population, can only carry on minimum essential health department services. In many instances they are only meeting needs on an emergency basis. Our problem, and one not peculiar to Maryland, is that of providing an adequate staff in terms of numbers and preparation, of making better use of the present services, and of developing cooperative relationship with those agencies now giving public health nursing services other than the county health departments.

During the next six months, through careful study of the calls which are received for nursing service and of the needs for such a service, we hope to be able to determine: (1) the amount and type of nursing services needed and the groups needing such care (2) the amount of nursing supervision necessary to develop and carry on a complete community public health nursing program (3) the kinds of records and reports needed for the service (4) the opportunities this service offers for more productive teaching (5) the number of patients carried for bedside nursing service that are known to other services, such as child hygiene, tuberculosis, maternity, and others (6) how the program affects the public health nurses' relationship with practicing physicians (7) whether or not some of the work can be done by subsidiary workers and registered nurses untrained in public health but working under the supervision of the public health nurse, and (8) whether the service should be offered to all the members of the community on a free, part-pay, and full-pay basis.

During this period of study and exploration, public health nurses will include nursing care of the sick as an integral part of health teaching whenever possible. In order that they may have the necessary equipment to give nursing care in the homes, the bag equipment has been increased in selected counties. The service will be explained to private physicians and they will be encouraged to use it to the extent it is available. Emergency orders and nursing procedures are in the process of development. In-service educational programs will be available to those counties where there are no supervising nurses. This will include assistance in the orientation of all new staff nurses and review of the procedures used in giving nursing care in the homes for all nurses. Consultation service from the Central Department is available to all counties in developing and administering a bedside nursing service. At this time every effort is being made to fill existing vacancies. New positions have been created in those counties where there is a great need for nursing service.

As the program has been discussed in the counties by the chief of the Bureau of Medical Services and the medical social worker, who is assisting in the development of the program, there has been revealed a need for a better understanding and utilization of community resources. Meetings have been called in many of the counties by the county health officers at which representatives from local and state agencies discussed their services. These meetings and discussions have brought out again and again the fact that one agency cannot adequately meet all the needs presented by families who are in trouble, and that the job is one of teamwork.

That our families living in the counties of Maryland need the care which public health nurses can give when the service includes sickness care and health teaching cannot be doubted. Economically and administratively it would seem desirable to have these services an integral part of the county health program. The scope of the program in each county should be based on a study of nursing needs and resources. It will necessarily depend upon community planning, available personnel, and funds.

REFERENCES

Maryland State Planning Commission, Committee on Medical Care. Medical Care in the Counties of Maryland. The Commission, Baltimore, April 1944.

Riley, Robert H. Medical Assistance Programs in the State of Maryland. Council of State Governments, Chicago, February 1946.

"Medical Care." *Maryland Health Bulletin*, October 1945, p. 67.

Fisk, Helen L. "Public Health Nursing and the Medical Care Program." *Maryland Health Bulletin*, January 1946, p. 94.

Roberts, Dean Winn. "The Program for Medical Care of the Medical Indigent in the Counties of Maryland Which Has Been Endorsed by the Medical and Chirurgical Faculties of Maryland." *Journal of Pediatrics*, October 1945, p. 384.

SCHOOLS APPROVED FOR TRAINING PHYSICAL THERAPISTS

By Council on Medical Education and Hospitals of the American Medical Association

Name and location of school	Medical director	Technical director	Entrance requirements*	Length in months	Classes Start	Tuition	Certificate, Degree, Diploma
Children's Hospital, Los Angeles	Samuel S. Mathews	Lily H. Graham	a-b-c	12	Feb.Aug.	$200	Diploma
College of Medical Evangelists, Los Angeles[1]	F. B. Moor	A. H. Carlson	c	12	Jan.July	$215	Certificate or Degree
University of California Hospital, San Francisco[1]	Frances Baker	Margery Wagner	a-b	12	Mar.Oct.	$150	Certificate
Stanford University, Stanford, Calif.[1]	Wm. Northway	Lucille Daniels	a-b-d[2]	10	Quarterly	$409	Certificate or Degree
Northwestern University Medical School, Chicago	John S. Coulter	Gertrude Beard	a-b-d	12	JulyOct.	$300	Certificate
State University of Iowa Medical School, Iowa City	W. D. Paul	Olive C. Farr	b-c	9	Mar.Sept.	None	Certificate
University of Kansas School of Medicine, Kansas City, Kans.	Gordon M. Martin	Ruth G. Monteith	c[3]	10	Feb.Sept.	$25[4]	Certificate or Degree
Bouve-Boston School of Physical Education, Boston	Arthur L. Watkins	Constance K. Greene	c[3]	36	Sept.	$400yr.	Degree
Harvard Medical School, Boston	Frank R. Ober	Janet B. Merrill	a-b-c	9	Varies	$300	Certificate
Boston University, College of Physical Education for Women, Sargent College, Cambridge, Mass.	Louis Howard	Adelaide McGarrett	H.S.	36	Oct.	Varies	Degree
University of Minnesota, Minneapolis[1]	Miland E. Knapp	Sara E. Kollman	a-b-c	12	Jan.	$200	Certificate
Barnes Hospital, St. Louis	F. H. Ewerhardt	Beatrice F. Schulz	a-b-c	9	Oct.	$200	Certificate
St. Louis University School of Nursing, St. Louis[1]	Alexander J. Kotkis	Sr. Mary Imelda	a-b-c[3]	9	Sept.	$250yr.	Certificate or Degree
Columbia University, New York City	Wm. B. Snow	Josephine Rathbone	a-b-c	10	Feb.Sept.	$480	Certificate
New York University School of Education, New York City[1]	George G. Deaver	Elizabeth C.Addoms	a-b-c	9	Feb.Sept.	$450	Certificate or Degree
Duke University School of Medicine, Durham, N. C.[1]	Lenox Baker	Helen Kaiser	a-b-c	12	Oct.	$200	Certificate
D. T. Watson School of Physical Therapy, Leetsdale, Pa.[1]	Jessie Wright	Kathryn Kelley	a-b-c	12	Oct.	$200	Diploma
Graduate Hospital of the University of Pennsylvania, Philadelphia, Pa.[1]	George M. Piersol	Katherine S. Sutherland	a-b-c	12	Sept.	$200	Certificate
University of Texas School of Medicine, Galveston	G. W. N. Eggers	Ruby Decker	a-b-c	9	Jan.	$100	Certificate
Richmond Professional Institute and the Medical College of Virginia, Richmond, Va.**	Frances Hellebrandt	Josephine Buchanan	a-b-d	12	Sept.	$200	Certificate or Degree
University of Wisconsin Medical School, Madison[1]	Elizabeth Grimm	Margaret Kohli	a-b-c	9	Sept.	Varies	Certificate

*Courses are so arranged that any of the entrance requirements will qualify students for training. a = Graduation from accredited school of nursing; b = Graduation from accredited school of physical education; c = Two years of college with science courses; d = Three years of college with science courses; H.S. = High school graduation.

**Approved also for 6 months emergency course for Navy nurses.

[1]Male students are admitted.

[2]High school graduates accepted for a four-year course leading to A.B. degree; students admitted quarterly and tuition is $143 per quarter.

[3]High school graduates accepted for four-year college course.

[4]Nonresidents charged additional fee.

—From *The Physiotherapy Review*, March-April 1946.

(For any possible changes, prospective students are advised to check with the schools regarding starting time and tuition.)

Student Observation in a VNA

By MILLICENT KAY, R.N.

SHOULD THE UNDERGRADUATE student nurse be permitted, during her two weeks' visiting nursing observation, to make visits alone to the home and render nursing care to the patient? The Yonkers Visiting Nursing Association believes that through careful planning, teaching, observation, and guidance the student is capable of assuming this responsibility.

We recognize that some students, undergraduate and graduate, take to public health nursing like ducks to water, while others have neither the aptitude nor the interest necessary for this specialty. Our program is flexible and geared to the individual student's needs and abilities. Some require more supervision than others, and it was for this reason that an educational supervisor was secured to assist with staff education and to be responsible for the adequate planning and guidance of the student.

Here are some of the highlights of this association's program. Most of the students are within a year or less of finishing training in a school of nursing—some will say, "I have only 279 days left to finish." They generally arrive, two at a time, at the office well ahead of 9 a.m., sitting very straight and probably wondering with mixed feelings about this new experience. From the fixed expression on their faces it is difficult to decide whether they are anticipating their stay with the agency with pleasure or apprehension. They are greeted by the educational supervisor and shown to their desks where record boxes, each labelled with the student's name, are awaiting them. It gives the students a feeling of belonging when they recognize they have been expected.

Their schedule for the two-week period is explained to them. This consists of conferences and demonstrations, home and clinic observations and, to their great joy, the responsibility and privilege of making a few home visits "on their own." One student was asked how she felt about this. She remarked that when she graduated she would be expected to know a great deal and suddenly to take on the responsibility of a graduate nurse. She asked, "How can we if we don't get a chance to learn how it feels to be on our own?"

On their first day they meet the executive director who welcomes the student nurses, explains briefly the agency's policies and organization and tells them to whom they are to report for advice and guidance. Then they have an introductory conference with the educational supervisor. In this they are taught some of the basic principles of public health nursing, with strong emphasis on the individuality of the patient. A brief background of the growth of public health nursing is discussed with some indication of its future plans, needs, and problems. One student said, "I am beginning to see that public health nursing is just another link in the chain." When encouraged to develop her thinking in more detail so that the real meaning of her experience would stand out clearly, she saw that the chief concern of all nurses was the individual patient, the "whole" person. Another phrased it this way, "At first the bridge between hospital nursing and home nursing seems very wide, but now I'm beginning to see that it is not a bridge at all, but only a continuation."

In the short time allotted we can only open the door and give them a glimpse of the vastness of the field of public health nursing and thus acquaint them with another area of nursing. This teaching comes at a time when many of them are beginning to think about which branch of nursing they should enter after graduation.

Instruction is given in the VNA's policies and functions and its relationships to the

Miss Kay is educational supervisor, Visiting Nursing Association, Yonkers, New York.

other social agencies in the community. When we come to the subject of daily reports and record writing and reasons for the various required entries, the need for and value of accurate and full recording is stressed, not only during the student's affiliation but also in her hospital work and future career.

In the afternoon, "bag technique" is demonstrated and explained. How their fingers itch to get into "their" bags which bear their name, the agency's name and telephone number. They are reminded that the supervisors are as close as the nearest telephone if the students at any time need advice or help. Or if they should get lost, all they have to do is call the office. This adds to their feeling of security. They practice their bag technique until it is down pat. While their interest is still high, we start "the home visit" conference. The setup resembles as closely as possible the actual situation in the home. Learning takes place so much more rapidly and efficiently when the learner sees the similarity between two situations. Then they are given a short "breathing spell," after which they study assigned reading to reinforce the teaching given that day. At 5 p.m. they hand in the completed day sheet they learned about in the morning conference and go off duty with a happy "Goodnight" and "Thank you." The fixed expression has been replaced by one of anticipation. Tomorrow they are going into the field to observe.

ON THE SECOND morning they are assigned to the staff nurses who will take them into the district for that day. They have been told to observe the approach to the patient and family, the adaptations of nursing skills to the home situation, the improvisations used, and the teaching accomplished. When the staff nurse calls the office at 1 p.m. she reports that she has met the student who had returned to the hospital for lunch, and that they are now on their way again.

The students return to the office about 4 p.m. and discuss their observations with the educational supervisor. They are often surprised by the friendliness of people and bubble over with enthusiasm at this discovery. After they have calmed down a little they get down to brass tacks and through questioning and discussion reveal how much they have learned. It is amazing how much young eyes, ears, and minds absorb. It is stimulating to get their thoughts and reactions. One found that "teaching is being carried out almost constantly although I am sure that most persons do not recognize it as such because it is done so informally." That's just how we do our teaching, isn't it? Another said, "Confidence and trust must take time to build and each person must be handled differently." An experienced nurse could not express this truth any more effectively.

In order to provide a good all-round picture of the community and the agency's services, on the third day the student accompanies another staff nurse to visit in another district. The morning is spent observing home visits, and in the afternoon the students go to a preschool clinic which is conducted by the Yonkers City Department of Health. These observations have been arranged for with the director of public health nurses of the Department, who in turn has given the students' names to the clinic nurses. When the student goes into the clinic she is greeted by name and made to feel at home.

The services of the clinic are explained, and students sit in on the conferences with the mothers, children, doctor and nurse. Thus a different area of pediatrics is discovered and the student again learns from actual experience other community functions for the protection of the health of its citizens. One student reported that she was interested to find that so many youngsters from poor families had been immunized. She had been under the impression that only people who could afford it were able to give their children this protection.

THE NEXT DAY, the fourth, is the day the students have been anticipating with a mixture of feelings—excitement, hope, and some apprehension. Each is given a case they have previously visited with a staff nurse so that they will be in familiar surroundings when they take off on their "solo flight." The care to be given the patient is the type with which the student is quite familiar and the patient is not acutely ill. Very careful consideration is given in the selection of patients for student nurses. They study the records thoroughly, and this is one time that motivation for records does not have to be drummed up! The patient is discussed by the student,

the staff nurse, and the supervisor. The students trace on the wall map the route to the patients' homes and memorize the trolley or bus number. One gets the feeling that this visit is the most important thing in the world to them right now.

The nursing bag which they have checked and rechecked is picked up and grasped tightly. Some try to swing it over their arms as nonchalantly as the veteran public health nurse, but even though they do, they still reveal their feelings. Nor is it all excitement. They have a grave feeling of responsibility. Hasn't someone written about the "long, deep thoughts of youth?"

After their briefing they prepare to leave and their remarks are good indices of how they feel in being trusted to do a good job of nursing. "This will be the best bath I've ever given." "I'll make Mr. White just as comfortable as possible," and so on.

When they return, the consensus of their remarks indicates deep satisfaction in accomplishing the task given, and pride in their ability to transfer their knowledge from the hospital situation to that of the home. A recent student said, "The first day you go out alone is the first day that you really understand what the visiting nursing association is. It is said a picture is worth a thousand words but one actual visit yourself is worth a thousand pictures. You can watch someone do something a great many times but still can't learn to do it yourself until you've actually done it. . . ."

When the student has completed giving care to "her patient," and it is amusing to see how quickly she identifies with the agency after she has completed her first visit alone,—"my patient"—"my bag"—"our services"—, she returns to the office where the educational supervisor goes over the record, the content of the visit, and asks and answers questions related to the work the student has done. The students are generally thrilled by a feeling of accomplishment. They have justified the trust laid upon them. This experience has given them faith in their ability to use their nursing skills in other than the familiar hospital situation. They have "solo-ed," and returned without a "crack-up!"

On the afternoon of the fourth day one of the students visits a chest clinic conducted by the Department of Health. The other student generally accompanies a staff nurse for further observations in the home. She will go to the chest clinic the following week. For many of them this visit to a chest clinic is most revealing. After listening to the explanations of the clinic nurse the student begins to see not only the advances made in control of tuberculosis, and public health contributions to this control, but also some of the problems with which the nurses in this field are constantly confronted.

One young nurse wrote quite indignantly about people breaking their appointments. In her written report of her observations she asked, "Why do patients break their appointments and why don't all contacts come in for examination?" Those of us who have done this type of nursing can echo the questions although we cannot always provide adequate answers!

The next day the supervisor makes home visits with the students followed by individual conferences in the afternoon. The students appear to have no trepidation about the supervisory visits, accepting them as part of a training program, and asking many questions relating to public health nursing and nursing in general while en route to the patient's home.

Saturday morning the students visit one patient each and spend the rest of the time studying. When they leave the office at noon the usual expression is, "Gosh, a week gone already."

The second week consists of more home observations, further visits to "their patients," and attending mothers' classes. In all, students visit 10 to 15 different patients. Time is spent each day in study and at this time the two required reports are written, one on reactions to the home observations and the other on the clinic observations. Individual conferences are held daily with the educational supervisor before the student goes into the field and upon her return. The students become part of the VNA family during the two weeks they are here and generally it is with great reluctance they clean up their bags and set them up for the classmates who will follow.

THE READER MAY wonder what the reactions are of the staff nurses who contribute so largely to a program of this type, the patients, and their families. Do the patients feel that

the care given is adequate? Do families accept the student nurses? This agency believes that they do since patients and families have called the office for "the nurse in the gray uniform" (a cadet nurse) to revisit, or "will you please send that nice little nurse who visited mother yesterday" . . . and expressions of disappointment are received when we explain that the student has returned to the hospital. From time to time the supervisors and staff nurses ask the patients if they have liked having the student nurses visit them and the majority of them have given overwhelming approval. A patient who had just recently returned home from the hospital said that she had received good care from the students in the hospital and could see no reason for the same care not being carried out in the home. She had a point there.

The staff nurses are most cooperative and willing to assist in the shaping of this teaching program. They try to arrange their work in a manner that will afford the student the greatest opportunity to see public health nursing in its fullest sense. They are the ones who actually show the students how the agency's policies are carried out. They explain the complications of the family situations and the students find that "mental hygiene" is not just the name of a course but an essential tool in dealing with people, well or sick. The general consensus is, "The students certainly are live wires; they keep you on your toes; you have to keep up with your reading in order to answer some of their questions." On the other hand, the students have been most sincere in their appreciation of the staff nurses' part in their training and have commented upon the cooperative spirit which the staff shows them during their affiliation.

In a monetary sense the student program is considered costly to an agency (the school of nursing pays a fee of $10 for each student) but in a practical sense it is not money spent but invested for the experience awakens the student to some knowledge of another field of nursing. She learns how patients live and how agencies work together to improve the health of the community. The student is given a chance to face responsibility alone and she accepts it. Her understanding of the patient grows. The community indirectly benefits by the experiences which help to develop self-confidence and ability in the undergraduate nurse—the graduate registered nurse of tomorrow.

Food Package Plan for the European Hungry

A very concrete means of individual or group assistance to avert famine abroad is presented by the Cooperative for American Remittances to Europe, Inc., through its CARE food package plan. A CARE package is the famous 10-in-1 package of Army rations that put the American soldier into the field the best fed fighting man in the world. The Cooperative has 3 million of these packages, which will be distributed overseas to supplement the relief programs of voluntary agencies and UNRRA. Each CARE package will feed a family of four a supplementary meal of approximately 2,800 calories each day for two weeks. Each contains about 29 pounds net food content, averages 40,400 calories, and includes balanced menus combining meats and vegetables, sugar and cocoa, puddings and cereals, jam, butter and milk. CARE can now accept orders for these packages at $15 each and will guarantee delivery overseas to any designated individual, group, church or other category of people in Austria, Czechoslovakia, Finland, France, Italy, the Netherlands, Norway, and Poland. Where no beneficiary is designated, CARE's overseas representative in consultation with local welfare authorities will make the distribution.

An organization can participate in two ways: (1) by sponsoring in its name shipments of bulk consignments of CARE packages to designated groups or professions or for general distribution or (2) by urging members to send individual CARE packages. Remittances should be mailed, along with a remittance application blank (obtain locally or from New York) to CARE, 50 Broad Street, New York 4.

Selling Service

By DOROTHY E. WIESNER

IN THE 1945 Yearly Review the National Organization for Public Health Nursing asked nonofficial agencies whether or not they sold any service by the hour other than bedside care, and what were the charges per hour for such services.

Among 228 nonofficial agencies replying, 74 answered that they sold service by the hour, 137 did not, and 17 did not reply. Tables 1 and 2 show the agencies selling service by the hour according to size of agency and section of the country.

TABLE 1. AGENCIES SELLING SERVICE BY THE HOUR, BY AREA OF COUNTRY

Area of country	Number in sample	Number selling service	Percent selling service
Total agencies	228	74	32.5
New England	71	18	25.4
Middle Atlantic	70	31	44.3
East North Central	41	14	34.1
West North Central	15	4	26.7
South Atlantic	14	2	14.3
East South Central	1	—	—
West South Central	3	—	—
Mountain	1	—	—
Pacific	12	5	41.7

TABLE 2. AGENCIES SELLING SERVICE BY THE HOUR, BY SIZE OF AGENCY

Size of agency	Number in sample	Number selling service	Percent selling service
Total agencies	228	74	32.5
100 and over	3	3	100.0
50-99	5	4	80.0
25-49	20	13	65.0
15-24	24	8	33.3
10-14	24	13	54.2
5-9	59	20	33.9
2-4	78	13	16.7
1	15	—	—

Of the 74 agencies selling service by the hour, 44 sold 1 kind only; 17 sold 2 kinds; 10, 3 kinds; and 3, 4 kinds. Of this last group two sold industrial nursing, nursery school nursing, school nursing, and also service to schools of nursing. The other sold industrial nursing, group instruction, school nursing and service to schools of nursing.

Among other kinds of service by the hour were the following: health supervision at day camps and YWCA camps, service at keep well stations, juvenile home, assistance in orthopedic work, teaching of public health nursing courses at an approved program of study, and supervision of an orthopedic program in a nearby agency.

There were 120 instances of selling service by the hour for which the charges per hour were given. The service sold most frequently by the hour was for industrial nursing, 32 agencies reporting this kind of service. Other nursing services in the order of their frequency were to schools, to nursery schools, to schools

Miss Wiesner is NOPHN statistician.

TABLE 3. AMOUNT CHARGED FOR SERVICE BY THE HOUR OTHER THAN BEDSIDE CARE IN NONOFFICIAL AGENCIES

Kinds of nursing service sold by the hour	Total instances	By amount charged: Less than $1.00	$1.00 to 1.24	$1.25 to 1.49	$1.50 to 1.74	$1.75 to 1.99	$2.00 to 2.49	$2.50 and over	Other reply
Total instances	120	2	13	20	28	7	23	13	14
Clinic nursing	6	1	2	—	1	—	—	2	—
Committee work	—	—	—	—	—	—	—	—	—
Industrial nurse in plant	32	—	2	2	7	1	10	1	9
Nursery schools	26	1	5	6	6	2	5	—	1
Physicians' office	5	—	—	2	3	—	—	—	—
Group instruction	5	—	1	—	1	—	1	2	—
School work	27	—	3	7	7	4	3	—	3
Schools of nursing	11	—	—	1	1	—	3	5	1
Other	8	—	—	21	22	—	13	34	—

[1]Day camp (2 agencies).
[2]Keep well station and day care center.
[3]YWCA camp.
[4]Juvenile home and orthopedic (2 agencies).

of nursing (reported by 11 agencies), clinic service (6 agencies), group instruction (5 agencies), and in physicians' offices (5 agencies).

Table 3 shows the variations in the charge per hour made for these services. The lowest charge was 80 cents per hour by the La Jolla, California, Visiting Nurse Association for nursery school work. The highest was $6.67 by the St. Paul, Minnesota, agency for teaching in schools of nursing. Adjustments in charges were made by a number of agencies according to the numbers of hours sold, the use of the public health or practical nurse, the particular shift on which the nurses served in industrial work and whether full- or part-time nursing service was used in the plant. One agency, the Starr Center of Philadelphia, for its school work charged $1.50 per hour for inspection and $1.75 for assisting the school physician.

The variations in the charges shown indicate a need for studies of costs of service per hour for other than bedside care.

ADDITIONAL SUMMER COURSES

New York

Buffalo. University of Buffalo. July 1-August 10. Principles of public health nursing, teaching in public health nursing, including practice teaching, history of nursing and current trends, the guidance program in schools of nursing, seminar in nursing and nursing education. In addition to the advanced professional courses available, students may plan programs covering study in sociology, psychology, child psychology, the family, educational psychology, et cetera, in the period from August 12 to September 21.

For further information, write to School of Nursing, 25 Niagara Square, Zone 2.

THE AMERICAN JOURNAL OF NURSING FOR JUNE

Practical nursing and the changing professional attitude . . . Dorothy Deming, R.N.

The ANA and the Wagner-Murray-Dingell Bill, S. 1606.

Early rising in postoperative care . . . Nola Smith Sheldon, R.N., and James B. Blodgett, M.D.

Finding a job with Uncle Sam . . . Dorothy Deming, R.N., and Ruth A. Heintzelman, R.N.

Infectious hepatitis . . . Richard B. Capps, M.D.

Nursing care of patients with infectious hepatitis . . . Ola V. Baxter, R.N.

Medical care insurance and the nurse . . . Margaret C. Klem, R.N.

TWI methods of teaching auxiliary nursing personnel . . . Olive White, R.N.

The drying of plaster casts . . . Helen Bruck, R.N.

Nursing education

Social Security

DURING the decade which has elapsed since the Social Security Act was passed the words "social security" have become household words with a meaning which tends to go beyond the terms of the Act itself. For most of us "social security" has come to stand for support in old age, the means to acquire proper medical care for ourselves and families when we are sick or disabled, and maintenance during periods of involuntary unemployment,—in short, adequate protection at all times for all of us against all the common economic hazards.

It has been with the idea of eventually achieving this total goal by federal law that hundreds of amendments to the Social Security Act of 1935 have since been introduced in Congress. Except for a few changes, however, until 1946 little consideration has been given to the many proposals for extension and expansion of the Act. In February, the House Ways and Means Committee began hearings on possible amendments to the Social Security Act, including suggestions from a staff of experts appointed by the Committee itself, suggestions by the Social Security Board based on its own 10 years of experience, and provisions in the Wagner-Murray-Dingell Bill, S1606.

As it stands, the Social Security Act includes eight programs which may be grouped under three headings: (1) social insurance including old-age and survivors insurance, unemployment insurance (2) public assistance to the needy including old-age assistance, aid to the needy blind, aid to dependent children, and (3) health and welfare services including child welfare, services for crippled children, and maternal and child health.

Of the eight programs, the Federal Government operates only the first—old-age and survivors insurance. The states operate the other seven in cooperation with and partially financed by the Federal Government. The Social Security Board administers old-age and survivors insurance and participates in unemployment insurance, old age assistance, aid to the blind and to dependent children. The Children's Bureau cooperates with the states in the three child health and welfare programs.

Since public health nurses are especially concerned with changes in existing provisions for old age and survivors insurance (to which they are not now eligible if they are employed by philanthropic agencies or by offcial agencies), this program and proposed amendments are here described in brief.

A recent inquiry was circulated by NOPHN to 356 member agencies asking, "Do you approve of amendment to the Social Security Act to provide for old age and survivors benefits to employees of nonprofit agencies without changing the tax-free status of the employing agency and without inclusion of unemployment insurance?" Of 169 replying, all but 3 said "yes".

Present benefits under the law, according to "A Brief Explanation of the Social Security Act," by the Social Security Board, provide that regular monthly payments be made to covered workers when they reach 65 years of age and stop work, or to their families should they die at whatever age. This money is paid out of a trust fund into which both employer and employee now pay an amount equal to 1 percent of wages earned. This is scheduled to go up to 3 percent in 1949. The Social Security Board keeps each worker's account under his name and number.

The amount of the benefit payable to the covered worker is based primarily upon his "average monthly wage" up to $250 a month. This average is arrived at by dividing the total wages credited to his account since January 1, 1937 (or since the worker became 21, if that was at a later date) by the number of months that have elapsed up to the time the worker files his claim or dies. The benefit is figured by taking 40 percent of the first $50 of his average monthly wage, and adding 10 percent of the next $200. Then 1 percent of this total is added for each year he was paid $200 or more on covered jobs. One worker may not be paid less that $10 nor more than $85 per month.

Monthly retirement benefits are paid to (1) the worker when he is 65 or older and not working (2) his wife when she is 65 (3) his unmarried children under 16, or under

(Continued on page 320)

Reviews and Book Notes

THE SNAKE PIT

By Mary Jane Ward. 278 pages. Random House, New York, 1946. $2.50.

The Snake Pit, despite the current publicity, is not a sensational book—but it is a significant one which should give the complacent public something to think about. It is, essentially, the account of one woman's tortuous way back to normality from psychosis. We are given a glimpse into "Virginia's" (the patient's) thinking and reasoning during illness and convalescence—we see the cloudiness gradually lift and things begin to assume their proper perspective. It is a moving account and a plausible one.

But this is also the story of "Virginia's" life in a mental hospital, and it is perhaps this aspect of the book which holds most interest and significance for nurse readers. It is not a story of brutality, abuse, or even physical neglect; the author does not give the impression of being intent on a crusade or an "exposé." She records, calmly and dispassionately, the surroundings and events of her hospitalization.

We are given a picture of a hospital where "there wasn't enough of anything . . . not enough toilet paper, not enough food, not enough covers for cold nights. . . . There wasn't enough of anything except patients." We see the "ladies" being herded (the only accurate word for it) from dining-room to day hall, from bathroom to bed. There seem to be adequate therapeutic facilities — hydrotherapy, electric shock, et cetera—but seemingly administered in such a routine, impersonal way that their effectiveness may be questionable. Aside from occasional interviews with the doctor, there seems to be little evidence of interest in and attention to the individual patient.

It is a picture of barrenness—of indifference—of loss of personal dignity and privacy. The constant use of the patient's first name—the mass bathing where even the shower must be shared—the necessity to use one's dress as a handkerchief because no others are available. Hardly an atmosphere conducive to the development of mental health!

The nurses Miss Ward pictures are a pretty "broken-down" lot—kind enough, but impersonal and showing very little real understanding of mental illness. She portrays one former psychiatric nurse as having become psychotic herself—"she felt things too much. She tried to get some changes made. It was like beating her head against a stone wall. . . . A good nurse can't be any reformer. . . . " The author was unfortunate, perhaps, in the nurses she encountered; certainly there are many, even working under conditions similar to those described in this book, who have a genuine interest in their patients and an understanding of mental illness not shown by any of those pictured here.

One might also question the impression left by the frequent references to the dreaded experience of shock therapy. The uninformed reader may not recognize this as the useful form of therapy that it is.

These, however, are minor points. The major significance of the book is that it contributes more evidence to the present mounting indictment of conditions in our mental hospitals. Reform seems indicated; is Miss Ward's charge that "a good nurse can't be any reformer" true? Or need it be?

—Edith Patton, R.N., *Assistant Editor, American Journal of Nursing.*

PREVENTIVE MEDICINE AND PUBLIC HEALTH

By Wilson G. Smillie, M.D., D.P.H. 607 pp. The Macmillan Co., New York, 1946. $6.00.

This book is useful not only to the medical practitioner but also to those in allied professional fields, in gaining a point of view on public health as the responsibility of society as a whole. It maintains throughout a nonpartisan approach in the presentation of the many areas in the overall field of public health. Social and economic factors, stand-

ards and adequacy of care herein suggest a challenge rather than a solution.

The emphasis is definitely upon prevention. Also throughout emphasis is upon the function of activities pointing the way toward intelligent functioning of the health and welfare workers.

The many chapters, all pertinent to the health problems of today, are of necessity brief. Of special interest is the chapter "Geriatrics," in a nation with an aging population, with its emphasis preventing the present common ills of the aged. "Housing and Its Relation To Health" is particularly helpful in gaining further understanding of this environmental factor in family welfare. Likewise the chapter, "Venereal Diseases," contributes to an appreciation of this challenging social and health problem.

The social and health components in medicine, as implied here, carry much of interest to nursing which has endeavored to meet a similar challenge in its field of service.

The style of the book lends vitality and comes with a refreshing point of view in a time of unsettledness and unsolved problems.

—ELIZABETH M. HANSON, *Administrator of the Public Health Nursing Program, School of Nursing, University of Buffalo, Buffalo, N. Y.*

EMBRYOLOGY OF BEHAVIOR

By Arnold Gesell, M.D., Ph.D., Sc.D., and Catherine S. Amatruda, M.D. 289 pp. Harper & Brothers, New York, 1945. $5.00.

Consisting of a preface by the author, fifteen chapters, photographic section, appendices, references and index, the format is good. The first nine chapters include scientific and philosophical data, which the authors have reintegrated, garbing the whole precariously with the authority of his undoubted prestige in Child Study. In the last six chapters, Dr. Gesell introduces his contribution, the study of the premature or "fetal" infant.

Some confusion is created by inconsistencies. The beginning of the "fetal period" is defined once as the eighth week after conception (p. viii) and again as conception (p. 16). Darwinism is implicitly accepted and yet the author states "Species traits can *never* be transcended." (p. 161). There is dramatic force in the photographs of the rare, early human foetuses but no mention is made of the method of their procurement nor of the moral and ethical obligation that such material be acquired accidentally. The subtitle, "The Beginnings of the Human Mind," is misleading in view of the author's claims to a "thoroughgoing monistic approach" with "no necessity of defining causal interaction between mind and body."

Of value are the more than three hundred photographs of premature infants. Of specialized interest are the appendices, A giving the experimental data, and B discussing the diagnosis of age and its behavioural criteria.

—DOROTHY DONLEY-DOWD, M.D., *Assistant Professor of Psychiatry, Catholic University, Washington, D.C.*

FAMILIAL SUSCEPTIBILITY TO TUBERCULOSIS

By Ruth Rice Puffer, Dr.P.H. 106 pp. Harvard University Press, Cambridge, Mass., 1944. $2.00.

Any nurse who is interested in tuberculosis control and has a fairly good knowledge of tuberculosis will find this book tremendously stimulating. The material is presented in a vivid, terse manner with helpful explanatory charts. Sufficient background is also given through pertinently summarized scientific studies in this area so as to refresh the memory of the reader and make Miss Puffer's material more meaningful.

The author raises old but still timely, unanswered and intensely provocative questions such as, "Why does tuberculosis attack some individuals and not others?" The possible reasons for this are presented by the author with substantiating factual data.

The two principal concerns of this book are familial susceptibility to tuberculosis combined with exposure to the tubercle bacilli, and why knowledge of these factors is essential in planning any methods of control.

Detailed data is given of the study of tuberculosis mortality of siblings of tuberculous persons in Williamson County, Tennessee, both of index cases and consorts. One interesting conclusion from this study would appear to be that regardless of the agreement there may be as to reason, the siblings of persons known to have tuberculosis develop tuberculosis in adult life and die from the disease more frequently than those in the control group.

In the chapter titled, "Tuberculosis in Children of the Tuberculous," salient facts are presented to substantiate the premise that a relatively high proportion of children of both tuberculous parents with positive sputum and those with negative sputum ultimately develop the disease. All the other chapters are equally interesting and informative.

Certainly the material presented should be scrutinized and given serious consideration when planning long-range case-finding programs.

—MARGARET S. TAYLOR, R.N., *Nurse Officer, Public Health Nursing Consultant, Tuberculosis Control Division, U.S.P.H.S., Washington, D.C.*

JOBS AND THE MAN

By Luther E. Woodward, Ph.D., and Thomas A. C. Rennie, M.D. 132 pp. Charles C. Thomas, 301-327 E. Lawrence Ave., Springfield, Ill., 1945. $2.00.

The authors, one of whom is field consultant and the other, director, Division on Rehabilitation of the National Committee for Mental Hygiene, wrote this manual in response to numerous requests from employers for help in the development of reemployment programs for returned veterans. They state that one of its purposes is "to give orientation and assistance to those who will be employing, supervising, and counseling individuals with emotional problems: veterans, civilians, and displaced war workers, both men and women."

The major emphasis is on problems of veterans, but, naturally, the practical suggestions for counseling can be used with any employee. Chapter II, "Understanding Veterans Who Come Back Nervous," explains and illustrates in simple language the various nervous and emotional disturbances which the supervisor may encounter among his staff. The glossary gives an excellent outline in brief of these conditions.

Foremen and supervisors should find particularly helpful the chapter entitled, "Practical Techniques in Industrial Interviewing and Counseling." Distinction is made between types of interviews and the purposes of each. Procedures are suggested for those who have had no special training in counseling. Undoubtedly, personnel who have responsibility for helping employees to make job adjustments should have some in-service training and the material in this chapter could well be the basis for several group discussions. The authors make the point that in time those who wish to specialize in industrial interviewing and counseling "will have to be provided with training somewhat similar to that of social workers and psychiatrists," except that the emphasis will be placed on job relationships and adjustments.

Some other chapter headings are "Placing Veterans in the Right Kinds of Jobs," and "Treating Them Helpfully on the Job."

For reference purposes, a Bibliography on Mental Hygiene in Industry is given, annotated under four groups: (1) for executive and personnel managers (2) for counselors (3) for industrial physicians (4) general. A series of questions for use by discussion groups is also included.

All who share responsibility for helping employees to adjust to their work regardless of the field involved should find this manual of practical techniques helpful.

—JEAN E. SUTHERLAND, R.N., *Nursing Consultant, Nurse Counseling and Placement Office, United States Employment Service, New York, N. Y.*

PSYCHOLOGY FOR NURSES

By Maude B. Muse, R.N., A.M. 467 pp. W. B. Saunders Company, Philadelphia, fifth edition, 1945. $2.50.

Psychology should definitely function in the work of any profession. It should become a practical science in the solving of everyday problems and should give the student a scientific background in the field of his particular specialization. This is an unusually well written textbook in its field. It is an excellent guide for preparing nurses for service. The approach is timely and the book is written in a clear manner that should provide a better understanding of the individuals a nurse must deal with and what the attitude of the nurse should be.

The author, who is well qualified to write such a book, illustrates scientific principles from numerous situations that the nurse must of necessity experience in her profession. In addition to applying the laws of psychology to the work of nursing, the subjects of human growth potentials, personality development, motivation of behavior, mental conflicts and

maladjustment, individual differences, mental disorders and mental hygiene are exceedingly well discussed and applied to nursing techniques.

The psychological principles are splendidly summarized and questions and exercises furnish a practical method at the ends of the chapters for class discussion and review. The conciseness, comprehensiveness, and scientific quality make the book unique in its field.

—DANIEL R. HODGDON, *Dean of the School of Education, Seton Hall College, Jersey City, New Jersey.*

RECENT PUBLICATIONS AND CURRENT PERIODICALS

GENERAL

ADULT ADJUSTMENT OF FOSTER CHILDREN OF ALCOHOLIC AND PSYCHOTIC PARENTAGE AND THE INFLUENCE OF THE FOSTER HOME. By Anne Roe, Ph.D., and Barbara Burks, Ph.D. Memoirs of the Section on Alcohol Studies, Yale University No. 3. Published for the Section on Alcohol Studies by Quarterly Journal of Studies on Alcohol, New Haven, Conn., 1945. 164 pp. $2.00.

CONVULSIVE SEIZURES—HOW TO DEAL WITH THEM. By Tracy J. Putnam, M.D. J. B. Lippincott Company, Philadelphia, Pa., second edition, 1945. 160 pp. $2.00.

HOSPITAL REVIEW NINETEEN FORTY-FIVE. American Hospital Association, 18 East Division Street, Chicago, Ill.

The Individual Hospital, September 1945. 78 pp. Single copy, $1.25; quantities of five or more, $1.00.

The Future of the American Hospital System, November 1945. 63 pp. Single copy, $1.00; quantities of five or more, 80c.

NURSING IN PICTURES. By Ella L. Rothweiler, M.A., R.N. F. A. Davis Company, Philadelphia, Pa., 1945. 542 illustrations. $5.00.

OUTDOOR AND CAMPING EDUCATION FOR AMERICAN YOUTH. By E. DeAlton Partridge, Ph.D. *Michigan Public Health*, May 1946, page 83. Michigan Department of Health, Lansing 4, Mich.

POISONS — THEIR CHEMICAL IDENTIFICATION, AND EMERGENCY TREATMENTS. By Vincent J. Brookes and Hubert N. Alyea. D. Van Nostrand Company, Inc., 250 Fourth Avenue, New York, N. Y., 1946. 209 pp. $3.00.

PREVENTION, FIRST AID & EMERGENCIES. By Lyla M. Olson, R.N. W. B. Saunders Company, Phila., Pa., 1946. 591 pp. $3.00.

PROCEEDINGS OF THE NATIONAL CONFERENCE OF SOCIAL WORK. Selected Papers, Seventy-second Annual Meeting, 1945. Published for The National Conference of Social Work, by Columbia University Press, New York, N. Y., 1945. 407 pp. $5.00.

THE PUBLIC WELFARE DIRECTORY 1946. American Public Welfare Association, 1313 East Sixtieth St., Chicago 37, Illinois. Single copies, $1.50; 10 to 25 copies, $1.35; 25 or more copies, $1.20.

HOUSING

AN APPRAISAL METHOD FOR MEASURING THE QUALITY OF HOUSING. Part I—Nature and Uses of the Method. Committee on the Hygiene of Housing, American Public Health Association, 1790 Broadway, New York 19, N.Y., 1945. 71 pp. $1.00.

Part II, Appraisal of Dwelling Conditions, will be published in the summer, 1946; Part III, Appraisal of Neighborhood Environment, will be published in the fall, 1946.

PUBLIC HOUSING PAYS DIVIDENDS. Housing Authority of the City of Newark, 57 Sussex Ave., Newark 4, N. J., 1945. 10 pp. Free.

A STUDY OF THE SOCIAL EFFECTS OF PUBLIC HOUSING IN NEWARK, N. J. Housing Authority of the City of Newark, 57 Sussex Ave., Newark 4, N. J., Nov. 1944. 95 pp. Free.

This study was conducted by Dr. Jay Rummey, Professor of Sociology, University of Newark, and Consultant to the Housing Authority, and Sara Shuman, M.A., the Authority's Research Associate.

RURAL HEALTH

BETTER HEALTH FOR RURAL AMERICA. Plans for Action for Farm Communities. United States Department of Agriculture, Interbureau Committee on Postwar Programs. October 1945. 34 pp. For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. 20 cents.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

Margaret P. Ladd

NEW ORTHOPEDIC CONSULTANT

Just returned from service in the U. S. Army Nurse Corps as physiotherapist, Margaret P. Ladd, formerly orthopedic consultant, Worcester VNA, Massachusetts, joined the staff of the NOPHN in May as field consultant in orthopedic nursing. Miss Ladd received her formal physical therapy training at the Harvard Medical School as a scholarship student from 1942 to 1943. Prior to that she had orthopedic nursing experience with the staffs of the Boston VNA and South Carolina State Department of Public Health. She is a graduate of the Peter Bent Brigham Hospital School of Nursing, Boston.

NFIP MAKES THREE GRANTS TO NOPHN

Basil O'Connor, president of the National Foundation for Infantile Paralysis, has announced three grants totaling $78,650 to be made to the National Organization for Public Health Nursing. The largest grant, $33,750, is intended to provide continued advisory services by the orthopedic staff of the NOPHN to nurses and public health nursing agencies about the care and treatment of patients with orthopedic disabilities. Funds set up for this purpose will also be used to give advisory service to university postgraduate programs of study in public health and orthopedic nursing. A grant of $31,500 has been appropriated to aid in recruiting nurses for the public health field, to provide consultative services to local communities, and to prepare informational material about public health nursing. The third grant of $13,400 will be used to continue scholarships in orthopedic public health nursing.

These awards supplement $199,400 previously received by the NOPHN in the period 1939-1946 and bring to $11,017,692.34 the total appropriated by the National Foundation for all research and education in the field of poliomyelitis since founding of the organization in 1938. Activity of this type, like the actual treatment of polio patients, is supported by the March of Dimes.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Louise L. Cady	Buffalo, N. Y.—June 11-13
	Chapel Hill, N. C.—June 24-28
Ruth Fisher	Meriden, Conn.—June 6
Agnes Fuller	Indianapolis, Ind.—June 11, 12
Mable Grover	Pensacola, Fla.—June 17-20
Margaret P. Ladd	Roanoke, Va.—June 16
Sarah A. Moore	Detroit, Mich.—June 6, 7
Eleanor Palmquist	Salt Lake City, Utah—May 31-June 3. Ogden—June 3, 4.
Dorothy Rusby	Dayton, O.—2nd wk. June
Jessie L.Stevenson	Nashville, Tenn.—June 3-13
	Blue Ridge, N. C.—June 14-22
	Minneapolis, Minn.—June 24-29
Louise M.Suchomel	Dayton, O.—2nd week June
	Blue Ridge, N. C.—June 16-23

May field trips scheduled for NOPHN staff members after last month's magazine went to press included visits to Rochester, Buffalo, Cleveland, and St. Louis by Sarah A. Moore, and to Cleveland, Wenatchee, Washington, and Portland, Oregon, by Eleanor Palmquist. Ruth Houlton was in Washington, D.C., and Ruth Fisher in Atlantic City, N. J.

Many will save time between Biennial sessions for ocean bathing at Atlantic City.

RECORDS ROOM AT BIENNIAL

The Records Committee of the NOPHN at its last meeting recommended that a records room service be made available at the Atlantic City Biennial Convention, September 23 to 27. A Records Room is therefore being planned and will be located on the Ballroom Level of the Auditorium, Room 6, open from 9 to 5. Letters have gone out to presidents of SOPHNs and to directors of public health nursing in state health departments asking for the names of agencies with records that would be of interest. Mead and Wheeler, the company which publishes NOPHN record forms and instructions, have again offered the use of files and other equipment.

The Records Committee will be interested in receiving word of new and effective record forms or methods of writing records from any agency interested in submitting duplicate verbatim copies of such records with names disguised. Types of records to be included in the Records Room material are:

Acute communicable diseases
Adult health service
Antepartum
College health
Day sheets
Delivery
Industrial
Infant and preschool
Integration of services
Maternity cycle
Midwife supervision
Monthly reports
Noncommunicable diseases
Nutrition
Occupational therapy
Orthopedic
Planned parenthood
Posting sheets
Postpartum
Punch cards
Records of conditions limited to certain localities (malaria, hookworm, et cetera)
Rheumatic fever
School health service
Simplified record forms
Time studies
Tuberculosis
Venereal diseases

STATISTICS DISCUSSION AT BIENNIAL

Requests have come to NOPHN for a discussion of what statistics are necessary concerning public health nursing and what are the best ways of gathering them. If enough interest is shown, a small late afternoon meeting of not more than 50 directors and supervisors will be provided at the Biennial Convention in Atlantic City in September. It is planned to have this meeting provide a brief summary of the statistical material gathered by the agencies represented by the 50 persons present, a discussion of the statistical material required by Community Chests and Councils, by the insurance companies, U. S. Public Health Service, and the National Foundation for Infantile Paralysis. Use of posting sheets and punch cards will be reviewed.

If you would like to have someone from your agency attend this meeting, will you write at once to Dorothy E. Wiesner, secretary, NOPHN Records Committee, 1790 Broadway, New York 19, N. Y.

NOPHN CHARTER MEMBER DIES

Matilda L. Johnson, charter member of the NOPHN and a pioneer in public health nursing, passed away at her home in Evanston, Illinois, April 25. She had a long and varied career in nursing and was an inspiration to many young nurses throughout her lifetime. Her sister, Lydia R. Sheall, director of the VNA of Evanston, writes, "She was proud to have had a part in the meeting in Chicago in 1912 when the NOPHN was born."

Miss Johnson graduated from St. Joseph's School of Nursing in Chicago in 1898, at the time of the Spanish-American war. She and some of the other young graduates joined the government nursing service and were sent to Chicamauga and Chattanooga where typhoid fever was raging. She later joined the staff of the Chicago VNA and had the Hull House district for five years. In 1904 she went to Cleveland as superintendent of the VNA in which post she remained until 1914 when she was appointed field supervisor in Canada of the Metropolitan Life Insurance Company Nursing Bureau, one of the first three traveling supervisors of the Bureau. During the first World War she was loaned to the Red Cross to do some special work in Virginia. She returned to MLI and became superintendent of the Nursing Bureau in 1920; was appointed generalized supervisor operating out of Chicago in 1922. In 1931 Miss Johnson retired, but she kept up her interest in public health nursing both locally and nationally.

● Dr. Donald B. Armstrong, second vice-president, Health and Welfare Division, Metropolitan Life Insurance Company, has accepted membership on the NOPHN Advisory Council to succeed Dr. Milton J. Rosenau.

Mabel Wilcox, retiring president of the Kauai Nurses' Association, on the fourteenth anniversary of the organization and of her presidency, was presented with a life membership in the NOPHN by members of the Association at a banquet in her honor March 14, 1946 at Lihue, Kauai. Miss Wilcox, who received the presentation in recognition of her outstanding contribution to nursing, was chief public health nurse on the Island of Kauai for a number of years and has been very active in nursing affairs. A indicates Miss Wilcox, B, Thelma Hensler, incoming president. Life memberships are a welcome addition to the National's reserve fund.

100% AGENCIES

Since the first list of agencies with 100% membership in NOPHN was printed in the March issue, the ranks have been swelled by those agencies listed below. More and more this expression of loyalty in terms of membership shows an understanding that membership is a reciprocal effort.

The National Organization for Public Health Nursing stands back of its membership in terms of service, advice, standards, and keeps its membership aware of new trends and developments in the public health nursing field. Every nurse who is a member of NOPHN by her support of its program and policies strengthens the program which is planned for all public health nurses and for the best standards of nursing in communities.

Every added member means added strength. Those agencies listed below show great understanding of membership support. There is still chance for increased support and unlimited growth.

CALIFORNIA
Burlingame—American Red Cross Visiting Nursing Service
Los Angeles—Metropolitan Life Insurance Nursing Service*

COLORADO
Denver—Denver Public Schools, Health Service Department
Denver—Visiting Nurse Association*

CONNECTICUT
Portland—Portland District Nurse and Welfare Association*

GEORGIA
Atlanta—Metropolitan Life Insurance Company Nursing Service
Atlanta—Southeastern Area Nursing Service of the American Red Cross
Savannah—Chatham Savannah Health Council*

ILLINOIS
East St. Louis—Visiting Nurse Association of St. Clair County

KENTUCKY
Henderson—Metropolitan Life Insurance Company Nursing Service*
Madisonville—Metropolitan Life Insurance Company Nursing Service

MAINE
Dover-Foxcroft—Piscataquis County Health and Tuberculosis Association*

MASSACHUSETTS
Watertown—Watertown District Nursing Association**

MICHIGAN
Bay City—Public Health Nursing Service of the Civic League and City of Bay City*
Detroit—City Department of Health
Detroit—Visiting Nurse Association*
Grand Rapids—Kent County Health Department

MINNESOTA
Minneapolis—Community Health Service of Minneapolis*

NEW JERSEY
Bayonne—Visiting Nurse Association

NEW YORK
New York—Judson Health Center
Rochester—Visiting Nurse Association*

NORTH CAROLINA
Raleigh—Metropolitan Life Insurance Nursing Service of Raleigh

NORTH DAKOTA
Fargo—Nursing Bureau of City of Fargo Health Department*

OHIO
Cleveland—University Public Health Nursing District

OREGON
Portland—Multnomah County Health Department

PENNSYLVANIA
Lansdowne—Public Health Nursing Service, Delaware County
Philadelphia—Henry Phipps Institute*
Pittsburgh—Public Health Nursing Association of Pittsburgh (Homewood Substation)
Reading—Visiting Nurse Association
Scranton—Visiting Nurse Association
Williamsport—State Nursing Service

RHODE ISLAND
Woonsocket—Woonsocket Public Health Nursing Association

SOUTH CAROLINA
Greenwood—Greenwood County Health Department

TENNESSEE
Knoxville—Metropolitan Life Insurance Company Nursing Service*
Nashville—Metropolitan Life Insurance Company Nursing Service

WASHINGTON
Tacoma—Pierce County Health Department

HAWAII
Honolulu—Territory of Hawaii Board of Health, Bureau of Public Health Nursing

*Indicates an agency which has had 100 percent membership for five years or more.

**This agency was included in the 100 percent agency listing in the March issue, but due to a typographical error the asterisk indicating membership for five years or more did not appear after the name of the agency. Actually, Watertown District Nursing Association has been a 100 percent agency since 1923.

TRANSPORTATION FOR THE BIENNIAL

Florence Johnson, Chairman of Transportation for the Biennial, announces that executive secretaries of the state nurses' associations will act as state chairmen for transportation. Please feel free to consult your state chairman for any information you wish regarding your transportation to and from the Biennial. While we urge you to make your transportation arrangements early, please do not wait until then to send in your Hotel Reservation Blank Form with complete information. Hotel reservation forms are available at your state nurses' association office, and appear also in recent issues of the nursing publications: *Phn* News Bulletin, Spring 1946; PUBLIC HEALTH NURSING Magazine, April 1946.

The following table was compiled for Miss Johnson through the courtesy and cooperation of the local representatives of railroads, airlines, and the Greyhound Bus Lines:

APPROXIMATE RAILROAD FARES AND BUS FARES TO ATLANTIC CITY AND RETURN, AND AIRLINE FARES TO PHILADELPHIA ONE WAY

City	Round trip, first class	Round trip, coach	One way, lower berth	Air fare one way	Round trip bus fare
Albany, N.Y.	$ 21.22 (tax incl)	$ 13.51 (tax incl)	$ 2.35 (to N.Y.C.)	$ 10.70	$ 7.60
Albuquerque, N.M.	118.60	——	18.25	84.10	58.90
Atlanta, Ga.	47.75	33.40	6.70	33.15	20.10
Baltimore, Md.*	10.65	6.90	——	——	4.70
Boston, Mass.	28.38 (tax incl)	20.32 (tax incl)	3.39 (to N.Y.C.)	12.75	9.00
Buffalo, N.Y.	42.14 (tax incl)	23.69 (tax incl)	2.95 (to N.Y.C.)	——	——
Butte, Mont.	129.85	——	18.60	91.50	66.90
Casper, Wyo.	106.75	72.35	13.35 (from Chadron,	——	——
Charleston, S.C.	40.85	28.45	5.80 Neb.)	26.60	17.65
Charleston, W. Va.*	19.14	12.78	4.65	17.60	17.20
Charlotte, N.C.*	33.45	23.10	4.65	22.50	14.60
Chicago, Ill.	52.60	29.00	6.40	30.30	25.30
Cleveland, O.	33.70	17.85	3.50	16.15	15.85
Colorado Springs, Col.	105.20	——	14.75	71.55	52.65
Concord, N.H.	27.72	——	2.95 (to N.Y.C.)	16.55	11.45
Dayton, O.	47.21 (tax incl)	25.47 (tax incl)	6.67	22.50	19.75
Denver, Col.	105.20	——	14.75	71.55	52.65
Detroit, Mich.	42.90	23.25	4.95	20.15	20.45
Des Moines, Ia.	70.35	43.25	9.35	44.50	33.70
Fort Worth, Texas	88.15	——	13.05	61.75	39.45
Harrisburg, Pa.	12.88 (tax incl)	8.34 (tax incl)	3.05	4.20	5.05
Hartford, Conn.	19.27 (tax incl)	14.25 (tax incl)	1.04 (parlor car)	8.65	6.60
Houston, Texas	92.10	——	13.35	68.35	42.95
Huron, S.D.	84.50	54.55	11.35	——	——
Indianapolis, Ind.	54.28 (tax incl)	29.61 (tax incl)	7.71	27.60	22.35
Kansas City, Mo.	76.60	——	9.85	48.50	35.85
Los Angeles, Calif.	151.95	——	24.30	115.15	82.00
Louisville, Ky.	50.20	27.60	6.40	27.40	22.00
Miami, Fla.*	76.25	52.65	10.75	52.25	31.15
Milwaukee, Wis.	56.85	32.40	6.40 (from Chicago)	31.60	25.50
Minneapolis, Minn.	72.75	45.15	9.35	——	——
Montgomery, Ala.*	57.35	40.35	8.45	——	——
Nashville, Tenn.	52.70	35.00	6.95	33.50	22.05
New Orleans, La.*	74.40	52.60	10.40	53.60	31.05
New York, N.Y.	10.35 (tax incl)	6.61 (tax incl)	1.04 (parlor car)	4.40	3.60
Oklahoma City, Okla.	87.85	——	12.80	59.40	39.10
Omaha, Neb.	77.30	——	9.90	49.95	38.20
Philadelphia, Pa.	5.20 (tax incl)	3.68 (tax incl)	.75 (parlor car)	——	2.00
Phoenix, Ariz.	141.10	——	21.95	100.90	71.75
Pittsburgh, Pa.	30.30 (tax incl)	17.25 (tax incl)	4.03	11.80	12.45
Portland, Ore.	151.95	——	24.65	115.15	82.75
Portland, Me.	31.26	——	3.20 (to N.Y.C.)	18.55	12.55
Providence, R.I.	25.09 (tax incl)	18.18 (tax incl)	3.39 (to N.Y.C.)	11.05	8.55
Richmond, Va.	19.05	12.75	2.95	10.05	9.40
Salt Lake City, Utah	126.55	——	18.30	88.90	66.70
San Francisco, Calif.	151.95	——	24.30	115.15	82.00
Seattle, Wash.	151.95	——	24.65	115.15	82.75
Sioux City, Ia.	77.85	49.20	9.90	——	——
Springfield, Ill.	72.85 (tax incl)	40.42 (tax incl)	11.39	41.50	27.45
Springfield, Mass.	21.18 (tax incl)	15.51 (tax incl)	——	8.65	6.75
St. Louis, Mo.	61.00	——	7.85	37.85	28.75
Washington, D.C.*	13.05	8.40	1.20	5.65	5.85
Wichita, Kan.	86.25	——	12.80	57.35	39.10

All fares are subject to 15 percent Federal tax, unless otherwise noted.

All lower berth fares are quoted to *Philadelphia only*, unless otherwise noted.

*Fares from starred points are quoted to *Philadelphia only*.

THESE ARE ALL *ESTIMATED RATES* SUBJECT TO CHANGE WITHOUT NOTICE! CONSULT YOUR LOCAL AGENT FOR EXACT FARES.

Public Information Tips

NOW THAT the 1946 crop of annual reports is off the press and properly distributed, we can pause and comment about a few which were out of the ordinary.

One of these was the annual report prepared by the Visiting Nurse Association of New Britain, Connecticut. Believing that the usual printed or mimeographed report reaches far too few people, the Association decided to publish theirs as a report to the people in the New Britain *Herald* where potential readers would number at least 23,485 families. This was done in four installments and followed the practice of many commercial organizations. The first installment reported the number of home visits made by the five nurses on the staff; the second explained to whom these visits were made; the third featured work with diabetics and other people needing special treatments; and the fourth presented the financial report, names of the officers and of the professional staff. An appropriate picture and caption taken from the leaflet, "Know Your Public Health Nurse," (prepared by NOPHN and printed by courtesy of the Metropolitan Life Insurance Company) added to the interest. The annual report was also presented in the regular news columns of the paper.

The second annual report to catch and hold our eye was that issued by the Public Health and Visiting Nurse Association of Meriden, Connecticut. A two-fold leaflet, its format is attractive and the use of color and white space very effective.

The third report, in the form of a 5" x 8" calendar, was published by the Visiting Nurse Association of Syracuse, New York. On each page appeared the calendar for the month and underneath it a description of various phases of the work. All three reports are included in the NOPHN loan folders which members may borrow for a period of two weeks.

. . . . . .

We have been receiving many letters from public health nursing services throughout the country describing what they did to observe Know Your Public Health Nurse Week, April 7-13. These reports are all interesting but come from people with the "inside" point of view—that is, they are nurses or board and committee members already familiar with public health nursing. At the same time, we have been receiving unofficial reports from people who were also very interested in the "Week" but had the "outside" point of view —that is, they are public information experts not connected with public health nursing services. They have sent in constructive criticisms because they want to help public health nursing interpretation. One of these "outside" reports is particularly interesting and contains much that should make public health nursing groups stop and think more about the impression they are making on the public. Writing about the observance of the "Week" in the city where he resides, this correspondent states: "Generally I imagine the results would be considered from good to excellent, and a springboard for future public relations effort. From this first 'Week' many members of the nursing profession have undoubtedly learned valuable lessons. Let's hope they will make the proper application. Locally the radio end was better handled than the press phase. The proper emphasis was laid upon the professional side and upon the operating policies of individual units. By my standards, the human understanding side—so important in a public relations effort of this kind—was not sufficiently stressed. I thought that at times the bounce and enthusiasm of the nurses for their work did not come through the mike. Part of this was probably due to inexperience and nervousness. . . . . There definitely was not sufficient screening of voices. A number of poor ones got on the air whether by accident or an all-inclusive membership policy. There were some excellent voices, too. One by a young visiting nurse surprised me. She was extremely articulate. The leaders were good and not so good, which I suppose is typical in nonprofessional broadcasting . . . In conclusion, will repeat one point: local nurses, leaders, and rank and file, seem to take too much for granted. That attitude is not at all helpful in a public relations program. Frankly, it's a mistake on the part of nurses from leaders down. It's beyond me why a simple, courteous thing like a letter of thanks is so rarely forthcoming. Rather hard to understand why a mayor, cabinet officer, senator, supreme court judge will answer a letter and a nursing leader often does not. Hope your press books are bulky with material sent in by units throughout the country." E.W.

NEWS AND VIEWS

On National Nursing

PROGRESS REPORT ON "COMPREHENSIVE PROGRAM"

The National Nursing Council reports with pride the progress that has been made in the development of "A Comprehensive Program for Nationwide Action in the Field of Nursing." (The program in its entirety appeared in the *American Journal of Nursing*, September 1945, and the numbers below in parenthesis refer to sections in the printed report). Prepared by the National Nursing Planning Committee of the National Nursing Council, the "Comprehensive Program" is a composite of the postwar plans of the national nursing organizations. Classified under five areas in which programs for study and action should be developed, the plans have been developed as a series of projects to be undertaken by single organizations or by two or more together. Many had been launched months or even years before the "Comprehensive Program" was drafted and continue under their original auspices. In the case of certain of the *new* projects "steering committees" have been appointed to develop detailed plans for approval of the Planning Committee. When they reach the *action* stage they become the responsibility of the Council, but when several organizations are concerned, the Council has usually delegated supervision to "committees of interests," on which the several organizations are represented.

With the foregoing word of explanation action on the Program at various points can be reported in brief as follows:

A method is being sought to determine present nursing resources and estimate needs (Section I, A and B). It is recognized that information must be procured on a comparable basis, during approximately the same time period, and analyzed by a single agency. To avoid duplication and ensure coordination of work a committee composed of research and statistical staff of Council member organizations has been formed to clear all studies, and also a subcommittee to develop formulas on which to base estimates of nursing need. The committee to estimate nursing needs set up by the Council during the war is still active and will assist with the work.

In the personnel policies and practices study (Section I, D), plans call for making comparisons in (1) requirements for employment (2) general conditions of employment and their safeguards (3) job satisfaction at all levels of positions (4) social status in the community (5) inherent factors which influence the selection of an occupation and (6) controls of occupation. A steering committee is laying the groundwork for a "Study of the Socioeconomic Status of Nurses in Comparison with Workers of Other Selected Occupations." Ten national groups such as the American Home Economics Association and the American Association of Social Workers, have expressed keen interest and assured their cooperation.

Action is now being speeded in connection with the proposed study of the organization, administration, control and sources of financial support of nursing education (Section II, A). The steering committee that has been at work for some months has named a small group to work during the week of June 10th on information now available, with a view to beginning the major study immediately thereafter.

A Committee of Interests is developing a plan for a single professional accrediting body to bring together and into harmony the varied accrediting services now offered by 8 different national groups (Section II, E). Three approaches are being made: (1) Dr. George A. Works, an expert in the field of general education, has been employed to review common policies and procedures and assemble patterns for analysis. His plan will be ready for consideration by July 1st. (2) Information is being assembled by present accrediting personnel of the 8 agencies. (3) The committee members are studying philosophy and structure, basic policies, purposes, budget, and recommended organization.

Student nurse recruitment is in the hands of the Council's Committee on Careers in Nursing, which has a quota of 40,000 new students in 1946. At the same time the National Nursing Planning Committee is seeking the development of a long-term recruitment policy (Section II, H).

A committee of interests for the clearance of international nursing problems (Section II, I) has

been appointed. At its first meeting, March 13, the group urged that representatives from national and international nursing groups, UNRRA, USPHS, Children's Bureau, and foundations interested in international nursing be included on the committee. Consensus of the meeting was that American nurses because of their advanced educational and service opportunities, owe to nurses of other countries all possible organized help and leadership. The Committee hopes that a central clearing and information bureau may be set up that can be used both by nursing groups and the government.

In counseling and placement (III, A), in addition to the work of the member organizations, a regional experiment in counseling and placement of professional and practical nurses is being carried on by USES in New York City (see "Professional Placement and USES," PUBLIC HEALTH NURSING, May 1946, p. 229).

An active program for the development of community nursing councils (III, C) through the Joint Committee on Community Nursing Service of NOPHN, ANA, and NLNE has been under way since September 1945. A secretary to the Committee is available for field service. (See "Nursing Councils: From War to Peacetime," PUBLIC HEALTH NURSING, December 1945, p. 602).

At its March meeting, the Council decided that it has a responsibility "to stimulate an awareness among nurses of the implications of any legislative measures affecting nurses and nursing." (IV, A, 4). A Committee to Review Federal Legislation which affects nursing has been set up, with Ruth Houlton as chairman, to review legislation, interpret provisions that will affect nursing, and see that the profession's planning needs are served.

As to its information and public relations program (V), the Council reports that a great deal of such work is being done through the Council, the Nursing Information Bureau, the professional journals, the member organizations of the Council, and state and local nursing groups.—this report prepared for state nursing organizations and released to the nursing publications being a case in point. From time to time reports on activity in a single area or several will be made. As a project matures to the point where a broad program of information to the general public is in order, it will be launched.

RECRUITMENT MATERIAL

New materials are being made available to nurses active in recruitment programs throughout the country, both for the basic nursing training and for specialized services such as public health nursing. Among the leaflets published recently are: "Career Opportunities for Nurses in the Red Cross Nursing Service," published by the American National Red Cross; "Plan Your Own Career in Nursing," ANA Professional Counseling and Placement Service; "Nursing Offers You a Career Now," Nursing Information Bureau in cooperation with the Committee on Careers in Nursing of the National Nursing Council.

The Red Cross pamphlet presents the many and varied opportunities in Red Cross service, in the national as well as the local field. The NIB publication is directed to the prospective nurse and concerns the basic nursing education. An explanation of its services which should be useful to both the job seeker and the employer is contained in the leaflet of the ANA counseling and placement organization.

Many leaflets concerned with this broad recruitment and placement subject have already been released, and national agencies are constantly working on the preparation of such materials for the use of local and state groups. For example, the NOPHN has leaflets on some of the special fields such as tuberculosis and orthopedic nursing, and has recently revised its industrial nursing leaflet.

COUNCIL HAS NEW NEGRO NURSING COMMITTEE

A Committee of Interests on Negro Nursing to guide the work of its Negro Unit has been set up by the National Nursing Council under the chairmanship of Katharine Faville, dean, College of Nursing, Wayne University.

The Committee is developing a new approach to the Unit's task of integrating Negro nursing into the total nursing picture. (See PUBLIC HEALTH NURSING, March, p. 142.) Set up in January 1943, the Unit, under the guidance of Mrs. Estelle Massey Riddle, has accomplished a great deal, either through direct efforts or as a result of a new understanding that has developed. For example, the number of schools admitting both white and colored students rose during the war from 14 to 38. The employment of Negro nurses on an equal basis with white nurses increased appreciably, particularly in hospitals. Negroes in the Army Nurse Corps at the end of the war numbered 512; in the Navy Nurse Corps three.

Addition of an assistant consultant, Alma Vessells, to the Unit's staff in September 1945, through aid from the Kellogg Foundation, made it possible to accelerate the field work, which has offered consultation to schools of nursing, and speakers and consultation to nursing and community groups, both colored and white, where it was thought integration of Negro nursing could be furthered.

The basic philosophy back of the current revision

of work is that an integration program, to be widely effective, *must begin with the national nursing organizations*. Field work of Mrs. Riddle and Miss Vessells is now being curtailed as needed to make consultation service available to Council member organizations seeking to integrate Negro nursing into their total programs. In other words, the focus of effort has been shifted from the point where segregation directly affects the individual Negro nurse or student to the place where national programs are planned and policies established.

RECRUITING NURSES FOR POLIO CARE

The National Foundation for Infantile Paralysis is interested in compiling a list of registered nurses who will be willing to assist in the nursing care of infantile paralysis patients during the epidemic period, usually occurring in the months of July, August, and September. It is not possible to predict with accuracy where the greatest need for nurses will be during the summer of 1946. The need for experienced nurses will be as urgent as in the past and all registered nurses are asked to advise the National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y., of their willingness to serve either in their own state or any other state in the country.

For temporary work (three months), nurses will be paid at the prevailing private duty rate in the state in which they are working. Nurses who care for patients in isolation units will be paid the customary additional fee for communicable nursing. In addition, the National Foundation will pay travel expenses for nurses who take temporary positions. The nurse will be responsible for her own maintenance providing it does not exceed $75 per month, in which circumstance the National Foundation's Chapter will reimburse her for the additional cost. If living accommodations cannot be furnished in the hospital for temporary duty nurses, rooms will be secured for them by the hospital administration or by the National Foundation's Chapter.

Following the emergency period, in cases where the nurses accept permanent positions, salaries will have to be arranged by the nurses with the administration of the hospital or agency.

MISS FAVILLE COMMENDED

Katharine Faville has recently been warmly commended for her Council work in furthering the relocation of Japanese Americans by D. S. Myer, director of the War Relocation Authority, which is to be liquidated by June 30.

"As director of the Henry Street Nursing Association you employed on your staff the first public health nurse of Japanese ancestry to be hired during the war," wrote Mr. Myer. "You were also one of the first educators in the public health nursing field to assist Japanese American girls to get enrolled in eastern schools of nursing."

"You may be interested to know that at least 315 Japanese American girls enrolled in nursing schools during the course of our program and that approximately 195 Nisei students enlisted in the Cadet Nurse Corps. These figures indicate that the faith that you and others placed in these young Americans is well deserved."

From Far and Near

● The 7th Annual Convention of the American Public Health Association will be held in Cleveland, Ohio, November 11-14. All scientific sessions will be held in the Public Auditorium. The first day of the conference will be devoted to meetings of other groups. The NOPHN Education Committee and the Collegiate Council on Public Health Nursing Education will meet November 9-11.

● Medical societies of New York City's five boroughs have been informed that the housing shortage is still acute in Arizona. Physicians all through the country recognizing the advantage of Arizona climate for the relief of asthma and other similar conditions have been recommending to their patients a sojourn in that state. Hundreds have flocked to Arizona and added to the existing housing problem. Local chamber of commerce officials advise that definite arrangements be made for housing before a trip there is undertaken.

● The Annual Conference of the American Physiotherapy Association will be held at the Blue Ridge Assembly, Black Mountain, North Carolina, from June 16-June 22. The Association is celebrating its Twenty-Fifth Anniversary at this time. Registration fee for members is $2; for nonmembers, $3.

Shut-ins Paid for Radio Listening—A national service offers shut-ins the unique opportunity of being paid for listening to radio commercials. Radio Reports, Inc., a radio service organization hired by various national radio advertisers to check their commercials over local stations throughout the United

States, pays shut-ins to do its monitoring. The companies want to know if the commercials went on as scheduled, how they were handled, and exactly the time they came on. This plan has been in effect for almost two years, but Radio Reports is still in need of more monitors in certain cities. They are: Mobile, Montgomery, Ala.; Phoenix, Tucson, Ariz.; Bakersfield, Fresno, Sacramento, Stockton, Calif.; Waterbury, Conn.; West Palm Beach, Fla.; Albany, Columbus, Ga.; Kokomo, Muncie, South Bend, Ind.; Mankato, Rochester, Minn.; Jackson, Meridian, Hattiesburg, Miss.; Springfield, Mo.; Scottsbluff, Neb.; Utica, N. Y.; Charlotte, Durham, N. C.; Tulsa, Okla.; Du Bois, Erie, Reading, Pa.; Charleston, Columbia, So. Car.; Chattanooga, Cookeville, Knoxville, Tenn.; Austin, Corpus Christi, Tex.; Price, Utah; Richmond, Va.; Charleston, Parkersburg, Wheeling, W. Va. To qualify, listeners must be intelligent and able to carry out instructions. Public health nurses who know of shut-ins with arthritis, infantile paralysis, or other disabling conditions who might be interested in employing their time in this manner may wish to acquaint them with this employment opportunity. The pay is moderate, the assignments easy to follow, and the shut-in can make a little extra money while keeping occupied. If interested, write George I. Reid, Radio Reports, Inc., 220 East 42nd Street, New York 17, N. Y. for application blank.

Incidence of Poliomyelitis and Its Crippling Effects—A recent study of poliomyelitis and its crippling effects, over the past 15 years, undertaken by the U. S. Public Health Service and reported in *Public Health Reports*, March 8, 1946, indicates that an epidemic situation existed in some region of the United States nearly every year. The periods of exceptionally high incidence usually extended over 2 years, with the western part of the country having high rates one year and the eastern part, the other. Peak rates in the different geographic sections varied in terms of cases per 100,000 population, with the peaks occurring somewhat earlier in the south than in the north and west. There were high rates in both 1943 and 1944, and in 1945 rather large numbers of cases were reported in most of the geographic sections.

Family informants in house-to-house canvasses a few years ago reported that 5.7 per 1,000 living children 15-19 years of age had a history of poliomyelitis at some time since birth. Not all were paralytic—at 15-19 years of age, 4.5 per 1,000 living children gave a history of a paralytic attack, and 3.0 per 1,000 had residual paralysis of muscle weakness.

History rates of the disease were reported as rather consistently higher in northeast and north central cities than in the south. Histories were exceptionally high in the west, but, considering paralytic cases with residual effects, the west shows lower history rates than the north central section.

According to data on crippling effects, the legs are most frequently affected. In 85 percent of the children under 15 years of age with residuals of poliomyelitis, crippling involved the feet or legs; in 25 percent, the hands or arms were involved. In a considerable proportion of the cases, both the legs and arms were involved. Involvement of fingers and toes only was negligible.

Similarity of age incidence was greater between poliomyelitis and diphtheria than between poliomyelitis and scarlet fever or whooping cough. The survey data indicated the peak rate occurred at 3 years of age, with a decline in incidence noted as age increased.

Both incidence and mortality indicate a lower poliomyelitis rate among girls than boys. Measures of the severity of the disease, such as the proportion of cases that were paralytic, indicate that the disease is slightly less severe in girls than boys.

Case and death rates were lower for colored than for white persons living in the same geographic area.

According to the report, "Poliomyelitis death rates in the United States among residents of cities of various sizes indicate that the rate increases as size of city decreases, but rural areas and villages under 2,500 have lower rates than small cities and higher rates than cities of 100,000 and over."

A double check of cases indicated that 74 to 86 percent of poliomyelitis cases were reported to the health departments. In the northeast where the disease was definitely epidemic during the study year, a higher proportion was reported than in areas remote from the center of the outbreak.

Aluminum Therapy for Silicosis—The treatment of silicosis with aluminum powder, the study of which has been carried on in Canada in the past years and in this country more recently is described by Drs. D. R. Johns and S. J. Petronella in the *Monthly Bulletin* of the Indiana State Board of Health (September 1945). Research and study had found that the inhalation of large amounts of aluminum powder over many years had no harmful effect. It did not cause lung damage nor favor the development of tuberculosis or any other pulmonary condition. Further research and study in clinics set up for the treatment of silicosis had brought about the conclusion that inhalation of aluminum powder is harmless and gives no evidence of toxicity, results in improvement of workers' morale, health and production capacity, and prevents the development of human silicosis.

In view of this, the authors were sufficiently satisfied to place the treatment in operation at two different plants in East Chicago, Indiana.

The treatment was on a voluntary basis on the part of the employee. All of the men treated were either in contact with silica in molding, core, and

cleaning departments at the time or had been in the past. Each had a careful history taken and a chest x-ray, and upon the basis of the classification of these chest plates, treatments were given. The 276 subjects treated were classified as prophylactics and therapeutics. The number completing the treatment was 75.

Given under a registered nurse and under medical supervision, with careful attention to proper sterilization of parts used, the procedure was to start the men breathing aluminum powder through a rubber tube to the mouth for two minutes and increase one minute every day until five minutes were reached. The aim was to distribute the powder throughout the lungs. To be effective the powder must reach the terminal bronchioles or alveoli and be retained for a considerable time in order to permit the coating action on the silica. Thereafter, the "prophylactics" were given two treatments a week for a total of 30, and the "therapeutics" three times a week for a total of 40, each treatment for a maximum of eight minutes having been increased by one minute per treatment.

The aluminum powder is an active product made by grinding aluminum against aluminum in a small mill designed for this purpose.

Changes in symptoms were evaluated and the men were classified as follows: (1) those with definite improvement, 31 percent (2) no improvement, 28 percent (3) moderate improvement, 25 percent and (4) stationary negative or no change, 16 percent. The improvement was manifested by less cough, easier breathing, less fatigue, and improved appetite. None of these subjects became worse.

For further information about the use of aluminum powders in the prevention and treatment of silicosis, read also "Aluminum Therapy in Silicosis" by P. J. Bamberger, M.D. in *Industrial Medicine,* June 1945.

Nursing Personnel—Data on nursing personnel in schools of nursing education and professional and auxiliary nursing personnel are included in the Hospital Service report in the *Journal of the American Medical Association,* April 20, 1946. Comparative information on beds, average census, and admissions indicate that in the latter part of 1945 the registered hospitals were employing 144,724 graduate nurses, exclusive of 25,277 private duty nurses. For the preceding year corresponding figures were 125,458 and 23,949. Classification of the 1945 personnel was as follows: administrative personnel, 8,488; full time instructors, 4,174; supervisors and assistant supervisors, 18,786; head nurses and assistant head nurses, 26,769; full time general duty nurses, 68,902; part time general duty nurses, 11,826; and unclassified, 5,779. In comparison with 1944 there were fewer nurses in the unclassified group, but all other classifications were increased. The 1944 survey, however, did not include assistant superintendents. Increases were noted in all auxiliary nursing groups except practical nurses and attendants, whose numbers decreased by about 8,000.

The survey also showed a student enrollment in state accredited schools of nursing of 130,909 as compared with 129,879 in 1944 and 110,222 in 1943. The number of schools accredited by state boards of nurse examiners total 1,250; state accredited schools offering an affiliating course only, 171. The latter recommended 11,238 affiliated student nurses in 1945.

Education on Tuberculosis Control—Tuberculosis control was discussed at a series of staff education conferences for Oregon's public health nurses during April.

A meeting was held at each of the three state tuberculosis sanatoria with sanatoria superintendents participating in the discussions. Public health nurses from the surrounding area had an opportunity to become familiar with the policies of the sanatoria serving their areas.

Margaret Taylor, nurse consultant, Tuberculosis Control Division of the U. S. Public Health Service, was the principal speaker. Other speakers included Dr. J. Odell, superintendent of the Eastern Oregon hospital; Dr. J. Speros, director, Division of Tuberculosis Control, Portland Bureau of Health; Dr. G. C. Bellinger, superintendent, Oregon State hospital and Dr. E. T. Blomquist, director, Division of Tuberculosis Control, Oregon State Board of Health.

Emergency Food Measures—"More people face starvation today than in any war year, and perhaps more than in all the war years combined," President Truman reports to the citizens of this country. "The United States and other countries," he says, "have moved food into stricken areas in record amounts, but there is a constantly widening gap between essential minimum needs and available supplies." Diseases caused by malnutrition are taking a heavy toll in lives. Plague, already sweeping China, may well spread to other continents. Millions of people in this country want to make direct contributions to help save these war victims overseas, and the Emergency Food Collection in behalf of UNRRA, which began in May, has been set up to supplement the minimum subsistence diets planned in UNRRA's general relief program.

All money received will be used to buy more food. The food will be distributed free, without discrimination, on the basis of greatest need. Success of the collection depends in great part on the support of the women of America, who buy the food for the home and who can save food in the home. Foods needed, all of which must be in cans, include: condensed, evaporated, or dried milk, meat, fish, peanut butter, baby foods, baked beans, stews, soups, honey, fruits, juices, and vegetables. Food collection depots have been set up in every community for contributions of food or money.

To make possible this sharing of food with war-torn countries, a strong conservative program is needed. The so-called 80 percent-extraction flour to make wheat go farther is already on the market, and farmers are being encouraged to grow more wheat as well as to conserve grain in feeding livestock and poultry.

The following are other ways in which we can all participate:

1. *Eat less wheat products and fats* such as bread, cereals, macaroni, pies, cookies, cakes, salad dressing, and the like.

2. *Waste nothing.* Dress up leftovers. Buy no more than you can use. Clean your plate. Re-use, then salvage kitchen fats.

3. *Serve more plentiful foods* such as potatoes, eggs, poultry, fish, fruits, and vegetables in season.

4. *Keep up your victory garden* and preserve food at home.

Films are available for general community showings to increase knowledge and understanding of the world famine situation. Two of these are "Freedom and Famine" and "Suffer Little Children"; both available through your state agricultural extension service or local film distributor.

For literature and posters write the Office of Information, U. S. Department of Agriculture.

International Health Organizations — Plans are underway for an international conference in June for the purpose of establishing an International Health Organization. This conference is an outgrowth of the unanimous approval for "international action in the field of health" declared at the San Francisco Conference of the United Nations. A technical Preparatory Committee appointed by the Economic and Social Council of the UNO is meeting in Paris to prepare an agenda and draw up proposals for the conference. Dr. Thomas Parran, Surgeon General, USPHS, is a member of the Committee. The Economic and Social Council will review the recommendations of the Technical Committee at its second meeting in New York about May 1. The Committee's recommendations are to be submitted to all members of the United Nations by that time.

Dr. Parran is also chairman of an Advisory Health Group of national leaders in public health, medicine, nursing, sanitary engineering, and allied fields appointed by the State Department, which at its first meeting in October adopted a resolution urging the United States to take prompt action toward the establishment of the international health organization. The Senate in December 1945 passed a joint resolution requesting the President to take immediate steps toward the early convening of a health conference and the formation of an international health organization.

Present organizations which will be most affected by the establishment of an international health organization are the International Office of Public Health established in Paris by the Treaty of Rome of 1907, the League of Nations Health Organization, established in 1922, and the United Nations Relief and Rehabilitation Administration.

The International Office of Public Health, of which 59 nations are members, has been responsible since 1907 for the interchange, through diplomatic channels, of information concerning the occurrence and prevalence of the five "conventional diseases," smallpox, plague, cholera, yellow fever and typhus fever, among the member nations and has recommended changes in international agreements concerning quarantine measures against them. The Office was instrumental in developing the maritime sanitary convention of 1926, the aerial sanitary convention of 1933. In 1944, because of the increase of air travel and the development of effective typhus fever and yellow fever vaccines, it recognized the need for international action to modify the conventions of 1926 and 1933.

The United Nations Relief and Rehabilitation Administration undertook the task and developed new maritime and aerial conventions which 17 nations have accepted for a limited period. The Health Division of UNRRA has carried on the international exchange of epidemiological information required under the conventions with such assistance as could be made available under war conditions. The continuation of these conventions beyond the UNRRA period is one of the elements of urgency in the formation of the new organization.

The Health Organization of the League took many forward steps in the field of international health which are expected to serve as a guide to the contemplated new organization. Of greatest significance was the assistance it gave to nations, upon request, in strengthening their national health services. Its other important contributions included international health cooperation in the conduct of studies of malaria, nutrition, rural hygiene, cancer, and leprosy; in the standardization of drugs and biologicals; and in the stimulation of international exchange of students and experts. At the outbreak of war the League was initiating studies in housing and physical education.

Another health organization, whose activities are limited geographically in scope, is the Pan-American Sanitary Bureau. It has remained active during the war, expanding to take on new responsibilities occasioned by the war. The international health conference in June is expected to discuss means by which the Bureau, in addition to present activities, may serve to strengthen the new organization in a regional capacity.

The work of the Food and Agriculture Organization of the United Nations (see PHN, December 1945, p. 645) is also directly related to world health.

Our Readers Say . . .

The "Week"

We were very glad to participate in "Know Your Public Health Nurse Week" and feel this interest and publicity in our own community were invaluable. We feel the "Week" might be even more effective if state and local committees could be furnished with supplies without charge—supplies such as the kits, posters, and literature.—A FIRM BELIEVER IN THE "WEEK."

NOPHN wishes very much that it might be financially able to carry out your suggestions, but unfortunately we do not have the budget for doing so. The only way we can afford to issue any materials in large quantities is by asking local communities to help pay part of the cost. NOPHN did underwrite a large share of the cost of preparing the kits and other materials. What local communities paid represented only a fraction of the total budget that was required. NOPHN can issue publicity aids and other printed material to help local agencies interpret their services only by one of these methods of financing—by local agencies paying the actual cost of the materials or by increasing dues to NOPHN to the extent that we can afford to distribute materials free in large quantities.

The budget for Know Your Public Health Nurse Week came from money that the Board and Committee Members Section was able to raise from outside sources. This was a very small amount, but a large share of it went toward paying for the materials which were offered at less than cost.

We found that many communities were apt to confuse the "Week"—which was purely an educational campaign—with the money-raising campaigns conducted by the American Red Cross, the National Tuberculosis Association, Community Chests and Councils, and others. In these campaigns large quantities of materials are issued free because a percentage of the money raised locally in these campaigns goes to the national organizations. In other words, local communities pay for all leaflets, posters, and other publicity aids even though the fact may be less apparent in money-raising campaigns.

Perhaps the time will come when we can find a fairy godmother but until then it looks as if we will have to continue to ask local communities to share in the cost of leaflets, posters, and other publicity materials which they use to promote their own services.

Biennial

I am a public health nurse and a very active member of my district nursing association as well as the SOPHN. It is my understanding that this year at the Biennial there will be no important public health nursing meetings held during the sessions of the House of Delegates. Does this mean I can safely accept an invitation from the SNA to be an official delegate to the ANA convention?—A PUBLIC HEALTH NURSE.

Yes, the Biennial Convention has been planned so that no other NOPHN meetings will be held when the House of Delegates is in session. (See PUBLIC HEALTH NURSING, May, page 211.) It is true that public health nurses have frequently been appointed by their SNA's to serve as delegates and have been torn in their desire to serve as a delegate and also attend public health nursing meetings of importance to them. This year public health nurses may safely serve as representatives of their states to the ANA House of Delegates and also attend NOPHN meetings as there is no time conflict. It is important that public health nurses as members of their SNA's participate in the meetings of the House of Delegates.

About Uniforms

Our Association is about to face the "bare facts" of the uniform shortage. Because of the inability on the part of our local uniform company to obtain grey cotton material, we have decided to give our order to a national uniform company.

While we are now in dire need of immediate action, the nurses will not likely want to order a large number of uniforms if there is any possibility that the national public health nursing uniform will soon be a reality.

I would appreciate your letting me know if we can expect any definite action on the national uniform and if possible, a statement as to when we might plan for this change.—OLIVE MCNELIS, CHAIRMAN, UNIFORM COMMITTEE, PUBLIC HEALTH NURSING ASSOCIATION OF PITTSBURGH, PA., INC.

The NOPHN Uniform and Symbol Committee has been working hard on the project, but we have been held up because it has been difficult to find a satisfactory symbol. However, an outstanding designer has plans for a uniform well under way and we hope to have some uniforms to show at the Biennial in September when the membership will be asked to vote on the adoption of a national uniform. Even if a national uniform is adopted, it will not be possible for manufacturers to go into production in time for winter.

The Separate Nursing Council

Our city has an active Health Council. Would a separate nursing council be any more than a duplication?—R. C. OMAHA, Neb.

If as the result of the efforts of an active health council, nursing service in your community is satisfactory to producers and consumers alike, perhaps

you do not need a separate nursing council. Answering the following questions may help you decide:

Have all phases of nursing been included in health and hospital surveys and studies made in your community?

When changes relative to hospital or health buildings, health administration, personnel practices, and the like are contemplated in your community, is technical advice sought from the nursing profession when nursing is affected?

Is the nursing service satisfactory which is available to patients with tuberculosis, mental illness, communicable disease, or chronic conditions?

Is the service given by practical nurses understood in relation to their need for training, supervision, and licensure?

Are the salaries and employment conditions of nurses in the hospital and health agencies such as to attract and retain sufficient nurses of the caliber desired?

Are young women of your community who are interested in a career of nursing given guidance as to prerequisites for entering a school of nursing?

Are the nursing services known and used by the people who need them?

It is evident that these questions can not be answered without study and technical interpretation. All relate to matters vital to the community. A health council concerned with *all* aspects of community health would find it impossible to spend the time necessary to give considered replies, much less to outline a proper course of action.

Nursing is an integral part of any plan for better health. In the planning nurses can best make their contribution through an organized group representing both the profession and the public. A nursing council working parallel with a health council or a nursing committee within it is properly composed of citizens who use and pay for nursing services, representatives of hospitals and health agencies, and representatives of the professional nursing organizations which set standards. This interested group will be alert to community planning that has implications for nursing. It also provides a forum for furthering an understanding of community needs by the profession and of professional standards by the community. As a result of this understanding the nursing council is in a position to work effectively with a health or hospital council in those areas of their work which concern nursing.

Your Reservation

How can I be expected to make my hotel reservation for the Biennial five months in advance when I do not even have my railroad ticket and have no idea what time I will arrive in Atlantic City?

The Biennial is scheduled from September 23 through 27. If you want to play safe and be assured of a hotel room, then fill out the Hotel Reservation Form, giving complete information, and mail it to the Housing Bureau, 16 Central Pier, Atlantic City, N. J. (See PHN, April 1946, p. 202). You can always change the date and time of arrival if you have a confirmed reservation. If your plans go amiss and you find you cannot arrive on the day you planned, simply write the hotel from whom you received your confirmed reservation, giving them the change in date and time of arrival.

It is important to make your reservations immediately. Atlantic City hotels and A. H. Skean, manager of the Atlantic City Convention Bureau have been deluged with requests for hotel accommodations for September vacationists. The hotels have each set aside a limited number of rooms for the Biennial. Do not be disappointed by waiting any longer to make your reservation. It's first come, first served.

If you have a friend with whom you wish to share a twin-bedded room, be sure to give that individual's name. Hotels must have the names of all occupants who are to share rooms.

Social Security

(Continued from page 302)

18 if in school. To qualify, the worker must be "fully insured." This means he must have worked in a covered job about half the time between January 1, 1937 and the day on which he reaches 65 or dies, whichever is earlier. There is a minimum requirement that a worker shall have at least 6 quarters (3-monthly periods) of coverage to be insured. With 40 quarters of coverage he is "fully insured" for life.

Monthly survivors benefits are payable to the following survivors of "fully insured" workers no matter at what age they die: (1) unmarried children under 16, or under 18 if still in school (2) widow of any age while she has children entitled to benefits (3) widow after 65 (4) dependent parents if worker leaves neither widow nor children. Should a worker die without any survivor eligible for monthly benefits, a lump-sum death benefit equal to 6 times his monthly benefit may be paid to the widow, widower, child, grandchild, or parent in the order named. If no such survivor the lump-sum may go toward funeral expenses.

Amendments seek to include in the coverage of the Act employees of nonprofit agencies, self-employed workers, federal-state-local government employees, and certain others not now covered. It is also proposed to reduce the qualifying age for women to 60 years; increase the benefits payable; increase from $3,000 to $3,600 the amount of yearly earnings subject to computation for contributions and benefits; give social security credit for periods of service in the armed forces; pay benefits in case of permanent disability; make administration easier in many ways.

As to the other seven Social Security programs suggested amendments are also numerous. The Forand Bill (HR 5686) sponsored by the American Public Welfare Association proposes a thorough-going reorganization of the public assistance provisions.

IF A NURSE SHOULD ASK US WHY . . .

Why supervise the growing of raw materials? . . . to increase the nutritive value of Beech-Nut foods for babies. The quality of the finished product is directly proportional to the quality of the raw material.

Why a closed system type of cooking? . . . to assure highest possible retention of food values. First the foods are vacuumed and then pressure-cooked in stainless steel cookers. Then the filled jars are processed in pressure retorts. All cooking is done in the absence of air.

Why incubate sample jars at 98°F and 131°F? . . . to assure practical sterility in the finished foods. After an incubation period of two weeks, sample jars from each retort are tested for vacuum retention and pH. Other controls include total solids tests run every 2 hours and daily test kitchen checks for flavor, color and consistency.

Beech-Nut

STRAINED & JUNIOR FOODS

We invite your personal inspection or written inquiry

BEECH-NUT PACKING CO., CANAJOHARIE, NEW YORK

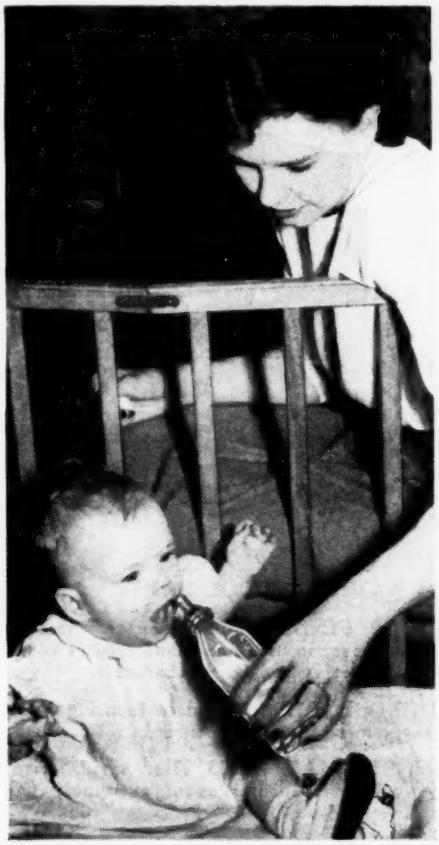
DYSMENORRHEA

For those certain days when you simply *must* keep working despite cramps and discomfort, why not find relief with 'Tabloid' 'Empirin' Compound? Thousands of other women use this professional formula as a routine every month for menstrual pains.

'TABLOID'
'Empirin' COMPOUND

In bottles of 100 and 500 • *Each product contains—Acetophenetidin gr. 2½* • *Caffeine gr. ⅓* • *Acetylsalicylic Acid gr. 3½* • *'Tabloid' and 'Empirin' Registered Trademarks*

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17



No Need To Coax

Babies take to modern Peter Pan Nipples because of their natural shape. Their air valves prevent collapsing, thus making it easier for babies to nurse and get more benefit from their food.

Mothers like Peter Pan because their handy tabs make them easy to apply. Paying a higher price will not get better quality than these modern, pure rubber Peter Pan Nipples.

The Pyramid Rubber Co., Ravenna, O.

Specialists in Baby Feeding Equipment

IT'S TRUE
IT'S HERE
IT'S A BULOVA

THE WRIST-WATCH YOU'VE WAITED FOR

For Work or for Dress
The Perfect Nurses' Watch

At last you can have one of these gorgeous wrist-watches. Fine, sturdy, dependable, beautiful. A genuine Bulova. A watch which will help you in your professional work, which you will be proud to wear at any other time and which you can buy unhesitatingly with the full knowledge that you are getting the best. Only $33.75 including all taxes.

Specifications

17 jewels; 10 karat rolled gold plate top; steel back; SWEEP SECOND HAND; silk cord with ratchet safety; FULLY GUARANTEED.

THE FIRST IN OVER THREE YEARS
Limited Quantity—Order NOW!

R. N. SPECIALTY COMPANY
15 East 22nd Street, New York, N. Y.

Gentlemen: Please send me one of these fine Bulova Watches.

☐ I enclose $33.75.
☐ Send it C.O.D. and I will pay the C.O.D. fees.

YOU WILL RETURN MY MONEY INSTANTLY IF I AM NOT GREATLY PLEASED

Name .....
Address .....
City and State .....

Baby-All PRODUCTS

Known & Approved by the Nursing Profession

As the name implies —*Baby-All* Products are designed ALL for babies! Tested, used, and approved by the medical and nursing profession for 15 years—*Baby-All* products may safely be recommended to mothers for the protection of their babies. Demonstrated to mothers in hospitals everywhere.

Baby-All NATURAL NURSER

Known the country over, *Baby-All* Natural Nurser set includes a screw-on, "no-colic" nipple, bottle, and cap. The breast-shaped, one piece, "no-colic" nipple screws onto the bottle quickly, easily, without fingers touching the nipple. The cap seals formula safely for refrigeration or traveling. Bottles made of PYREX or DURAGLAS easily cleansed and sterilized.

OTHER *Baby-All* PRODUCTS

Although the following *Baby-All* products are available in limited quantities—production will soon be normal. Upon request we will gladly mail you descriptive literature about "Baby-All" Formula and Sterilizer Outfits, Bottle Warmers, and Vapor-All Vaporizers.

SANIT-ALL PRODUCTS CORP.
GREENWICH, OHIO

THERE'S A LOT of COMFORT IN A TUBE OF V-E-M

If you are subject to common nasal irritations caused by simple head colds, dust, smoke, fumes, you'll find a quick spot of V-E-M up each nostril will make your nose feel much more comfortable. Get a tube of V-E-M at your drug store today.

Recommended by physicians for over 25 years.

Free sample to nurses on request.

SCHOONMAKER LABORATORIES, Inc.
Dept. PH **Caldwell, N. J.**

Foley FOOD MILL

Guaranteed by Good Housekeeping

Mothers save food and energy in starting Baby with the full flavor and food value of properly cooked FRESH vegetables and fruits strained through the Foley Food Mill. Just a few turns of the handle separate fibers and hulls and strain any food fine enough for the smallest baby or for any adult smooth diet. It is quicker, easier, and cheaper.

Quickly Strains

Carrots	Apricots	Peas
Spinach	String	Beets
Tomatoes	Beans	Prunes
Apples	Soups	Liver

How to Cook Baby's Food
Proper methods are given in booklet sent with Foley Food Mill.

$1.50 at Department and Hardware Stores

PROFESSIONAL OFFER TO NURSES:

FOLEY MFG. CO.
53-6 2nd St. N.E., Minneapolis 13, Minn.

☐ Send free booklet, Strained Food Methods
☐ Send Professional Offer to Nurses on Foley Food Mill

Name .....
Address .....

POSITIONS AVAILABLE

PUBLIC HEALTH NURSING lists "Positions Open" each month. Up to 50 words this service is *free to member agencies,* with a charge of $2 for an additional 50 words or less. To other organizations the charge is $2 for the first 50 words or less, and $2 for an additional 50 words or less.

WANTED—Obstetrical Supervisor in 100 bed hospital. Postgraduate work necessary. Hours 7 to 3:30. 48 hours week. Salary $175 per month. Apply Director of Nursing, East Liverpool City Hospital, East Liverpool, Ohio.

WANTED—Public Health Nurse Supervisor of a 5 nurse organization, located in Hamden, Conn., 8 miles from New Haven. Excellent surroundings and equipment. Serving community for 26 years. Qualifications include Public Health Nursing course and supervisory training. For further information write Mrs. Nathan H. White, Chairman, Hamden P. H. and V. N. A., Hamden, Conn.

WANTED—The Cleveland Child Health Association, a member of the Welfare Federation of Cleveland, supported by the Community Fund, is seeking a woman qualified to head a well-established prenatal instruction program. The following qualifications have been established. The candidate must be a registered nurse with a college degree and special training in obstetrics and public health. Previous teaching experience and knowledge of sewing are preferred. A rapidly expanding program offers unusual opportunities. The Association offers a salary of $3300 a year plus transportation with a month's leave each August. Inquiries may be addressed to the Journal or to Mr. Wirth Howell, Acting Director, Cleveland Child Health Association, 1001 Huron Road, Cleveland, 15, Ohio.

WANTED—Public Health Nurses for generalized nursing program. Salary range $210 to $240 per month. Under Civil Service, 40-hour week, vacation and sick leave privileges. Address: Director, Public Health Nursing, City of Seattle, 504 County-City Building, Seattle 4, Washington.

WANTED—Supervisor for Beloit Visiting Nursing Association, preferably one with a Degree in Public Health Nursing, Supervisor, two staff nurses employed. Desirable salary. Inquire: Mrs. Benjamin Fosse, Nursing Committee Chairman, Beloit V. N. A., 247 St. Lawrence Ave., Beloit, Wisconsin.

WANTED—Two Public Health Nurses. Straight School Nursing Program. Prefer someone under thirty-five years for permanent position. Staff of eight nurses. Excellent working conditions, five day week, good vacation period. Car essential. Salary open, compensation for use of car. Write Director of Health, Tacoma Public Schools, Tacoma, Washington.

WANTED—Public Health Nurse for staff position in official generalized program of Montgomery County, Md. A large suburban section of Washington, D. C., lies in this beautiful county, thus offering opportunity for both suburban and rural experience. Salary, $1900-2200, based upon education and experience in public health nursing. Make application to Montgomery County Health Department, Rockville, Md.

WANTED—Director of a Visiting Nurse Association having a generalized program including Child Health Service, Nursery School Inspection, Mothercraft classes and Industrial Nursing. Staff of seven nurses. Apply to Mrs. J. H. Strickland, 29 Davis Road, Saginaw, Mich.

WANTED—A qualified Public Health Nurse capable of organizing, developing, and directing the Nursing Service of a recently formed Visiting Nurse Association. Staff will be increased as service develops. An interesting and challenging field. Salary about $2100; car upkeep $275. Apply to: R. Hazel Berry, 46 Nichols St., Rutland, Vermont.

PUBLIC HEALTH NURSES ARE NEEDED IN GEORGIA—The State and County Departments of Public Health in Georgia invite qualified public health nurses to apply for permanent positions in Georgia. Staff nurses must have a minimum of six months postgraduate public health nursing education in addition to a liberal travel allowance. Supervisory nurses must have at least two years experience in public health nursing as well as one academic year of postgraduate training in public health nursing. Salaries range from $2100 to $2280 in addition to travel allowances. Scholarships are available for graduate nurses who are interested in receiving public health nursing training. Write Personnel Administrator, State Health Department, State Office Building, Atlanta 3, Ga., for application forms and full details.

WANTED—Cattaraugus County Department of Health has positions open for two experienced public health nurses. Beginning salary $1,920, car provided. Interview at our expense. Write to: Miss Ida McRoberts, Director, Public Health Nursing, 302 Laurens Street, Olean, New York.

THE CHICAGO LYING-IN HOSPITAL AND DISPENSARY OF THE UNIVERSITY OF CHICAGO
offers to qualified nurses the following courses:

(1) Four months—Basic course for those who wish broader experience in Obstetric Nursing. This course includes experience in hospital and dispensary services. Full maintenance is provided.

(2) Four months—Advanced course for those who wish to prepare for positions of responsibility in Institutional or Community Obstetric Services. Open to registered nurses who have had experience or advanced study in institutional or public health nursing. Charge made for part of maintenance cost.

The Gussie DeLee scholarship of $100 available each year for this course. The Nursing Education Department of the University of Chicago will grant credit to students who satisfactorily complete the advanced course and who meet the admission requirements of the department.

For further information apply to
DIRECTOR OF NURSING
5841 Maryland Avenue **Chicago 37, Illinois**

WANTED—Well qualified Public Health Nurse with degree to assume responsibility for the Tuberculosis Program. Must have academic work in Public Health Nursing. Generalized experience and administrative experience. Specialized Tuberculosis service desirable but not essential. For particulars write to Mrs. Elizabeth Earle, Director, Bureau of Nursing, Arlington, Virginia.

NEW PUBLICATIONS LIST!

NOPHN's new Publications List is now available. A copy is being mailed along with *Phn* to members. If you wish a copy, write to us—1790 Broadway.

Because of an increasing demand for large quantities of NOPHN leaflets, it is necessary to adopt a new policy in regard to price. Leaflets now listed as free on the NOPHN Publications List will be free in quantities from 1 to 10 only. For each leaflet over 10 there will be a charge of 3 cents; for every 100 copies, $2.50; for every 1,000 copies, $18.50. Prices for leaflets not now free in any quantity will continue as before. NOPHN member agencies will receive a discount of 10 percent on all orders of 100 or more leaflets. These charges cover the cost of printing, postage, and handling, but do not cover any of the cost of preparation. This will be met by the NOPHN.

Press of Thomas J. Griffiths Sons, Inc., Utica, N. Y.

high style

plus down-to-earth utility . . .

Here's a summer uniform for you . . . tailored as if for Newport or Fifth Avenue . . . but practical as a kitchen apron. You'll love the soft, saucy lines; the dropped shoulder with its gentle gathers and slight puff; the full seven-gored, fly-front skirt; the graceful, blue-buttoned waist, and the generous, pointed-flap pockets. All summer long you'll be grateful for the easy comfort of the pleated action back . . . and for its perfect fit. Best of all . . . it's made in easy-laundering, sanforized seersucker that scorns ironing and always looks fresh and pert.

IN THE SAME SUPERB SANFORIZED SEERSUCKER USED FOR ALL MILITARY NURSES' SUMMER UNIFORMS

No. 910 • Sizes 32 to 46
Blue and White Seersucker

$7.95 ea.

USE THIS COUPON TODAY

BRUCK'S NURSES OUTFITTING CO., Inc.
387 Fourth Ave., New York 16, N. Y.

Gentlemen: Please enter my order for:
..... No. 910 Uniforms @ $7.95 each.

☐ Check Attached. ☐ Money Order Attached.

☐ Send C.O.D. I will pay $..... plus C.O.D. and shipping charges.

Size..... Height..... Weight.....

Name .....

Address .....

City..... *Zone*..... *State*.....

BRUCK'S

387 FOURTH AVENUE
NEW YORK 16, N. Y.

17 NORTH STATE ST.
CHICAGO 2, ILL.